Molina Healthcare of California
Medi-Cal Managed Care Provider Manual

Imperial, Los Angeles, Riverside, Sacramento, San Bernardino, and San Diego Counties

MolinaHealthcare.com

MOLINA HEALTHCARE

Your Extended Family.

PROVIDER MANUAL

Molina Healthcare of California (Molina Healthcare or Molina)

Medi-Cal

2020

Dear Provider:

Welcome to Molina Healthcare of California (Molina) and thank you for your participation in the delivery of quality healthcare services to Molina's Medi-Cal Members. Enclosed is your Molina Medi-Cal Provider Manual. The Provider Manual covers the following listed counties in which Molina provides Medi-Cal managed care services:

	Imperial	Los Angeles	Riverside	Sacramento	San Bernardin	San Diego
Geographic Managed Care (GMC) Model				✓		✓
Two Plan Model Program	✓	✓	✓		✓	

This Provider Manual shall serve as a supplement as referenced thereto and incorporated therein, to your Molina Healthcare of California Services Agreement.

The information contained within this Provider Manual is proprietary. The information is not to be copied in whole or in part; nor is the information to be distributed without the express written consent of Molina. The Provider Manual is a reference tool that contains eligibility, benefits, contact information and Molina policies and procedures. This Provider Manual is also designed to provide you with assistance in all areas of your practice, from making referrals to receiving payment for your services.

The Provider Manual is reviewed, evaluated and updated as needed and at a minimum annually. All changes and updates will be updated and posted to the Molina Medi-Cal website at www.MolinaHealthcare.com. Contracted providers can also request a hard copy or CD version of the Provider Manual annually, which will be made available by contacting Molina, Monday through Friday, from 8:00 a.m. to 8:00 p.m., toll free at (855) 322-4075.

We appreciate and value your participation in Molina's provider network. We look forward to continuing working together to provide quality, culturally sensitive and accessible healthcare services to our Molina Medi-Cal Members.

Sincerely,

Paul Van Duine
Vice President of Network Management & Operations
Molina Healthcare of California

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1.0 CONTACTS: MOLINA HEALTHCARE OF CALIFORNIA

200 OCEANGATE, SUITE 100, LONG BEACH, CA 90802
MAIN PHONE: (562) 499-6191 TOLL FREE: (888) 665-4621 TTY: 711

DEPARTMENT	CONTACT INFORMATION
California Children Services (CCS) /Regional Center: The CCS/Regional Center Team coordinates referrals to CCS offices and manages the coordination of care for Members with CCS or Regional Center eligible diagnosis and conditions.	Healthcare Services: CCS/RC Team Phone: (844) 557-8434 Fax: (800) 811-4804
Child Health and Disability Prevention (CHDP): The Molina Child Health and Disability Prevention Department handles all CHDP Wellness Services and collects data from Encounter/Claims submissions for CHDP P4P incentive payments from Primary Care Practitioners to ensure the receipt of incentive payouts by MHC. All providers should submit timely claims and/or encounter data through normal and current reporting channels to ensure the receipt of the CHDP Wellness Services.: http://www.MolinaHealthcare.com	P.O. Box 16027 Mailstop "HFW" Long Beach, CA 90806 Attn: CHDP Department Phone: (800) 526-8196, ext. 127350 Fax: (562) 499-6117
Claims Department: *First Time Submission, Contested or Corrected Claims* Molina Healthcare is responsible for processing all of its Members' claims. **Those Providers/Practitioners with affiliations with a Molina Healthcare-subcontracted IPA or a shared risk group should submit claims and appeals to the affiliated IPA/shared risk group per their affiliation contract.**	EDI Claims: Payer ID: 38333 Phone: (877) 469-3263 Fee-For-Service Online Claim Submission through Molina's Provider Portal: https://provider.MolinaHealthcare.com
Community Engagement: The Community Outreach staff provides outreach and organizes participation in community events such as health fairs.	200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (800) 232-9998 Ext. 128091 Fax: (909) 890-4403
Credentialing: Credentialing Department verifies all information for Professional Review Committee approval on each Provider/ Practitioner to evaluate applicant's qualifications to be credentialed or re-credentialed. Re-credentialing is conducted at least every three (3) years.	200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (800) 526-8196, ext. 120117 Fax: (888) 665-4629
Cultural and Linguistic Services: The Cultural & Linguistic Services Department assists in the delivery of interpreter services and makes available cultural and linguistic consultation and training to assist providers in delivering culturally competent care.	200 Oceangate, Suite 100 Long Beach, CA 90802 Interpreter Services Information: Phone: (800) 526-8196, ext. 111032

DEPARTMENT	CONTACT INFORMATION
Department of Managed Health Care (DMHC): The Department of Managed Health Care (DMHC) is the regulatory body that licenses and oversees health maintenance organizations. DMHC accepts complaints regarding health plans by telephone. If a beneficiary has a grievance, he/she should contact the Plan and use the Plan's grievance process.	CA Department of Managed Health Care 980 9th Street, Suite 500 Sacramento, CA 95814-2725 Phone: (877) 525-1295 E-mail: plans-providers@dmhc.ca.gov
Department of Social Services (DSS): The DPSS Public Inquiry and Response unit handle inquiries from Medi-Cal beneficiaries regarding fair hearings.	California Department of Social Services State Hearings Division P.O. Box 944243, Mail Station 9-17-37 Sacramento, CA 94244-2430 Phone: (800) 952-5253 TTY/TTD: (800) 952-8349
Emergency Department Support Unit (EDSU): The EDSU is a dedicated team of Registered Nurses, available 24/7 to provide support in placement, issuing authorizations, facilitating Peer to Peer reviews, coordinating and facilitating placement, discharge planning needs, and Member follow-up.	Molina Healthcare of California EDSU 24/7: (844) 966-5462 Fax ED notification to: (877) 665-4625
Eligibility List Distribution: The Provider Services department is responsible for distribution of eligibility rosters (reports) on a monthly basis to all direct Primary Care Practitioners and IPA/Medical Groups.	200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (855) 322-4075 Los Angeles Fax: (855) 278-0312 Sacramento Fax: (916) 561-8559 Riverside/San Bernardino Fax: (909) 890-4403 San Diego Fax: (858) 503-1210 Imperial Fax: (760) 679-5705
Eligibility Verification: The Member Services Department verifies both Member eligibility and PCP assignment.	200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (888) 665-4621, option 1 IVR: (800) 357-0172 Fax: (310) 507-6186
Encounter Data: The Encounter Data Department handles all encounters for capitated services.	Email: MHCEncounterDepartment@MolinaHealthcare.com
Facility Site Review:	200 Oceangate, Suite 100 Long Beach, CA 90802

DEPARTMENT	CONTACT INFORMATION
The Facility Site Review is conducted as part of PCP credentialing process. Members are not assigned until facility has passed the site review. A Periodic Facility Site Review (re-review) is conducted at the time of re-credentialing every three (3) years.	Phone: (800) 526-8196, ext. 120118 Fax: (562) 499-6185
Health Care Options (HCO): The Health Care Options Contractor processes Medi- Cal Managed Care enrollments and disenrollment's. Please refer Members to the HCO call-in number.	Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850 Phone: (800) 430-4263
Health Education: The Health Education Department assists Members and providers in accessing health education and disease management programs and services (e.g., asthma, diabetes, smoking cessation, weight control).	200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (866) 472-9483
Inpatient Review: Registered Nurses and Medical Directors perform initial and concurrent review and provide authorization for admission/continued stay of Members in inpatient settings including acute, SNF, LTC, LTAC, Acute Rehab and Custodial. Notification to Molina is required within twenty-four (24) hours of inpatient admission.	Fax Medi-Cal clinical documentation to: (866) 553-9263 Phone: 844-557-8434 24/7 Afterhours, Weekends, Holidays call: (844) 966-5462
Member Services: The Member Services Department handles all telephone and written inquiries from Members regarding claims, benefits, eligibility/identification, selecting or changing primary care physicians, grievances, and appeals. Telephone calls are distributed to representatives via I.C.D. queue.	200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (888) 665-4621 Fax: (310) 507-6186 TTY/TTD: 711
Nurse Advice: The Nurse Advice Program is staffed during Molina Healthcare business hours and after hours by Registered Nurses for Member assistance and referral. Nurse advice is available 24/7	Phone: (888) 275-8750 (for English) Phone: (866) 648-3537 (for Spanish)
Pharmacy Authorizations: The Molina Pharmacy Authorization Desk is responsible for Molina's Drug Formulary inquiries and drug prior authorization requests. Requests for copies of Drug Formularies should be directed to Molina Provider Services.	200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (855) 322-4075 Fax: (866) 508-6445
Prior Authorization: Prior authorization decisions are completed within seventy-two (72) hours for expedited requests, and within five (5) business days for standard requests.	Prior Authorization Fax: (800) 811-4804 Phone: (844) 557-8434
Provider Dispute Resolutions: The Provider Dispute Resolution unit is responsible for providing a fast, fair and cost-effective dispute mechanism to process and resolve contracted and non-contracted	Molina Healthcare of California P.O. Box 22722 Long Beach, CA 90801 Attn: Provider Dispute Resolution Unit

DEPARTMENT	CONTACT INFORMATION
provider disputes. Formal disputes must be submitted in writing with supporting documentation.	
Provider Information Management (PIM): The PIM Department is responsible for the maintenance of Molina's Provider Network which includes all demographic updates, in addition to provider additions and terminations.	Fax: (562) 499-0619 Email: MHCPIM@MolinaHealthcare.com
Provider Education & Communications: The Provider Education Training and Communications staff informs Providers/Practitioners about Medi-Cal policies and procedures through Provider/Practitioner manuals, bulletins, newsletters, and workshops.	200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (800) 526-8196, ext. 127413Fax: (562) 951-1529
Provider Services: The Molina Healthcare Provider Services Department is the Provider/Practitioner liaison to the health plan's administrative programs. This department handles telephone and written inquiries from Providers/Practitioners regarding contracting, capitation verification, scheduling of in-service training, medical group affiliation questions, Member moves, and updates to the provider directory.	200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (855) 322-4075 Regional Local Office Numbers: Los Angeles Fax: (855) 278-0312 Email: MHC_LAProviderServices@MolinaHealthcare.com Sacramento Fax: (916) 561-8559 Email: MHCSacramentoProviderServices@MolinaHealthcare.com Riverside/San Bernardino Fax: (909) 890-4403 Email: MHCIEProviderServices@MolinaHealthcare.com San Diego Fax: (858) 503-1210 Email: MHCSanDiegoProviderServices@MolinaHealthcare.com Imperial Fax: (760) 679-5705 Email: MHCImperialProviderServices@MolinaHealthcare.com
Quality Improvement (QI): The QI Department is responsible for management and implementation of the QI Program, HEDIS and CAHPS (Member satisfaction) reporting and oversight of regulatory and accreditation standards. It updates and distributes preventive care guidelines and clinical practice guidelines.	200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (800) 526-8196, ext. 126137 Fax: (562) 499-6185
Vision Care: March Vision Care Group	Customer Service: (844) 336-2724

1.1 CONTACTS: IMPERIAL COUNTY

Molina Healthcare of California
Imperial Regional Office
(760) 679-5672
Send correspondence to:
1607 W. Main St
El Centro, CA 92243
Attn: Provider Services

Access to Independence of Imperial Valley
400 Mary Avenue, Suite D
Calexico, CA 92231
(760) 768-2044 phone / (760) 768-4977 fax
(760) 768-0466 TTY
www.accesstoindependence.org

Alternatives for Seniors
(888) 932-7747 phone
www.AlternativesforSeniors.com

Area Agency on Aging (AAA)
1331 S. Clark Road, bldg. 11
El Centro, CA 92243
(800) 510-2020 or (760) 339-6450 phone
www.co.imperial.ca.us/AreaAgencyAging/

California Children's Services
935 Broadway St.
El Centro, CA 92243-2396
(442) 265-1455 phone / (442) 265-1481 fax

Deaf Community Services of Imperial County
612 S J Street
Imperial, CA 92251
(760) 355-1078 phone
www.national.citysearch.com/profile/37216891/imperial_ca/deaf_community_service.html

Health Consumer Center of Imperial Valley
449 Broadway Street
El Centro, CA 92243
(760) 353-0220 phone / (760) 353-6914 fax

Imperial County Behavioral Health Services
202 N. 8th Street
El Centro, CA 92243
(442) 265-1525 or (800) 817- 5292 phone

Imperial County Behavioral Health Services: Adult Alcohol and Drug Recovery Program
2695 S. 4th Street
El Centro, CA 92243
(760) 482-2138 phone

In-Home Support Services (Imperial County Dept. of Social Services)
2995 South Fourth Street, suite 105
El Centro, CA 92243
(760) 337-6800 phone / (760) 337-5716 fax
www.imperialcounty.net (search for "In-Home Support Services")

Meals on Wheels - Imperial County
1331 South Clark Road
El Centro, CA 92243
www.meals-on-wheels.org

San Diego Regional Center
4355 Ruffin Road, Suite 200
San Diego, CA 92123-1648
(858) 576-2996 phone

1.2 CONTACTS: LOS ANGELES COUNTY

(subcontracted to Health Net)

AIDS Waiver Agency
AIDS Project Los Angeles
3550 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010
(213) 201-1422 phone

Calif. Children's Services (CCS) Program
County Department of Health
9320 Telstar Avenue, Suite 226
El Monte, CA. 91731-2849
(800) 288-4584 phone / (855) 481-6821fax

Child Health & Disability Prevention (CHDP) Program
City of Los Angeles (PM 160 Code: 352M)
9320 Telstar Avenue, Suite 226
El Monte, CA. 91731
(800) 993-2437 phone / (626) 569-9350 fax

City of Long Beach - Health Department
2525 Grand Avenue
Long Beach, CA 90815
(562) 570-4000 phone

CPSP Perinatal Services
600 South Commonwealth, 8th Floor
Los Angeles, CA 90005
(213) 639-6427 phone / (213) 639-1034 fax

Los Angeles County Department of Mental Health
550 South Vermont Avenue
Los Angeles, CA 90020
(800) 854-7771 phone

Substance Abuse Prevention and Control
1000 S. Fremont Avenue, Bldg. A-9 East, 3rd Floor
Alhambra, CA 91803
(626) 299-4193 phone / (626) 458-7637 fax

Regional Centers
Eastern LA Regional Ctr
1000 S. Fremont Ave
Alhambra, CA. 91802-7916
(626) 299-4700 phone

Frank D. Lanterman Reg. Ctr
3303 Wilshire Blvd. Suite 700
Los Angeles, CA. 90010-2197
(213) 383-1300 phone

Harbor Regional Ctr
21231 Hawthorne Blvd.
Torrance, CA. 90503
(310) 540-1711 phone

North LA Regional Ctr
200 Oakdale Ave Suite 100
Chatsworth, CA 91311
(818) 778-1900 phone

San Gabriel/Pomona Reg. Ctr
75 Rancho Camino Drive
Pomona, CA 91766
(909) 620-7722 phone

South Central LA Regional Ctr
2500 S. Western Avenue
Los Angeles, CA 90018
(213) 744-7000 phone

Westside Regional Ctr
5901 Green Valley Circle, Suite 320
Culver City, CA. 92030-6953
(310) 258-4000 phone

TB Control Program
2615 S. Grand Avenue, Room 507
Los Angeles, CA 90007
(213) 745-0800 phone / (213) 749-0926 fax

Women, Infant, & Children (WIC)
Antelope Valley: (661) 949-5805 phone
Long Beach: (562) 570-4242 phone
Harbor UCLA: (310) 661-3080 phone
Irwindale: (626) 856-6600 phone
Northeast Valley: (818) 361-7541 phone
Pasadena: (626) 744-6520 phone
Watts: (323) 568-3070 phone

1.3 CONTACTS: HEALTH NET

Molina Healthcare of California is sub-contracted under Health Net in Los Angeles County for the Medi-Cal program. As such, Members who are Medi-Cal beneficiaries enrolled in Molina Healthcare in Los Angeles County must contact Health Net's Member Services department for member related issues or inquiries. Health Net will coordinate as appropriate with Molina Healthcare of California to effectively respond to and resolve member issues.

Health Net Member Services (Medi-Cal Los Angeles)
1-800-675-6110

Molina Member Services (Medi-Cal- Riverside County and San Bernardino County)
1-888-665-4621

Health Net Nurse Advice Line
The Nurse Advice Line is staffed after business hours by registered nurses for Member assistance and referral.
1-800-675-6110

Health Net Website

Health Net's website offers information on member eligibility, claim status, Health Net reference materials such as the Medi-Cal Recommended Drug List, *Evidence of Coverage*, county-specific Medi-Cal operations manuals, forms, and information on how to contact Health Net with questions.
provider.healthnet.com

Health Net Community Resource Centers

Get help with insurance questions and enrollment forms.
Plus, learn about health classes and many other community resources.
East Los Angeles: 323-415-9120

Medicare Advantage Plans

Health Net Amber, Complete, Green, Gold Select, Healthy Heart, Jade, Ruby, Ruby Select and Sapphire: 1-800-949-3022, option 1. TTY users should call 711.

Acupuncture Services

Acupuncture services are covered through American Specialty Health Plans, Inc. (ASH Plans) for Health Net Medi-Cal Members. Physicians and capitated participating physician groups (PPGs) must refer Medi-Cal Members to ASH Plans for acupuncture benefits. To refer a Health Net Medi-Cal Member to an ASH preferred provider, contact ASH Plan provider services at 1-800-972-4226, option 2.

Claims

Send written correspondence, claims, tracers, adjustment requests, or denial reconsiderations to Health Net Medi-Cal Claims at the following address:
PO Box 14598, Lexington, KY 40512-4598

Communications

The Health Net National Provider Communications Department informs Health Net participating providers of Health Net's policies and procedures, and changes in contractual, legislative and regulatory requirements through provider operations manuals, updates, letters, and Online News articles.
12009 Foundation Place, Ste. 100, Bldg. B, Rancho Cordova, CA 95670
(916) 935-8346
Fax: 1-800-937-6086

Cultural and Linguistic Services

The C&L Services Department promotes access to care for Members who speak a primary language other than English and can help facilitate interpretation services.
cultural.and.linguistic.services@healthnet.com
1-800-977-6750
Fax: (818) 543-9188

Delegation Oversight

The Health Net Delegation Oversight Department oversees participating providers in all Health Net lines of business and assists them in understanding and complying with Health Net's requirements and those of state and federal regulatory agencies.
Fax: 1-866-476-0311

Electronic Data Interchange (EDI) Claims

Health Net encourages participating providers to review all electronic claim submission acknowledgment reports regularly and carefully. Questions regarding accessing these reports should be directed to the vendor or clearinghouse. All other questions regarding electronic claims submission should be directed to Health Net's EDI Department.
1-800-977-3568

Eligibility Verification

Health Net's Medi-Cal Provider Services Center verifies member eligibility twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year. Eligibility can also be verified online through Health Net's website at www.healthnet.com.
1-800-675-6110

Encounters

Contact the Health Net Encounter Department via email with encounter data questions.
Enc_Group@healthnet.com

Enrollment Services

Health Net's Enrollment Services Department is available to Medi-Cal Members to answer any questions regarding benefits and enrollment.
1-800-327-0502

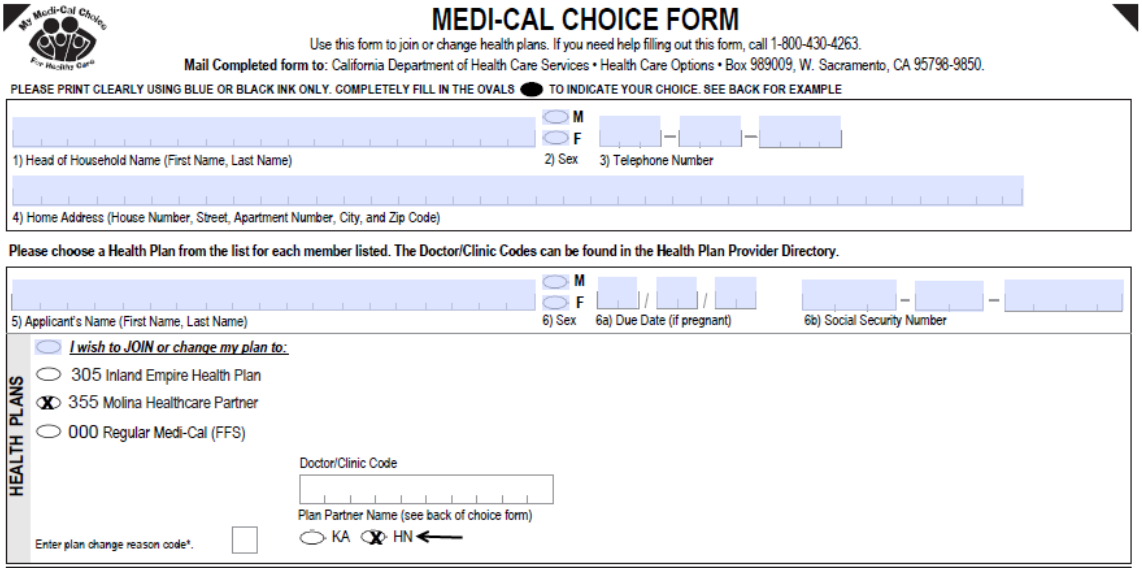
DHCS established the Health Care Options (HCO) referral process to provide Medi-Cal beneficiaries with information on the benefits of receiving health care services through managed care plans and to help the beneficiary choose a managed care plan. The HCO enrollment contractor is also responsible for assigning beneficiaries who do not choose a health plan on the Medi-Cal Choice form. At initial eligibility or annual redetermination, the HCO enrollment contractor sends an enrollment packet to Medi-Cal beneficiaries who do not make a choice at an HCO enrollment contractor presentation. The enrollment packet contains provider directories, a health plan comparison chart, enrollment instructions, a Medi-Cal Choice form, and a Medi-Cal Choice booklet.

Medi-Cal Choice Form

The beneficiary must select a health plan in his or her designated county and complete and mail back the Medi-Cal Choice form to the HCO enrollment contractor within 30 days of receiving the Medi-Cal Choice form from an HCO enrollment contractor. If the beneficiary does not select a health plan, the HCO enrollment contractor assigns one based on DHCS criteria.

To choose Health Net as a Medi-Cal managed care plan partner in Riverside (355) and San Bernardino (356) counties, Medi-Cal Members must first choose the health plan Molina Health Care Partner *and* select Plan Partner Name ***HN***.

Example only:



MEDI-CAL CHOICE FORM

Use this form to join or change health plans. If you need help filling out this form, call 1-800-430-4263.

Mail Completed form to: California Department of Health Care Services • Health Care Options • Box 989009, W. Sacramento, CA 95798-9850.

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK ONLY. COMPLETELY FILL IN THE OVALS ● TO INDICATE YOUR CHOICE. SEE BACK FOR EXAMPLE

1) Head of Household Name (First Name, Last Name) | 2) Sex M F | 3) Telephone Number

4) Home Address (House Number, Street, Apartment Number, City, and Zip Code)

Please choose a Health Plan from the list for each member listed. The Doctor/Clinic Codes can be found in the Health Plan Provider Directory.

5) Applicant's Name (First Name, Last Name) | 6) Sex M F | 6a) Due Date (if pregnant) | 6b) Social Security Number

HEALTH PLANS

I wish to JOIN or change my plan to:

305 Inland Empire Health Plan

355 Molina Healthcare Partner

000 Regular Medi-Cal (FFS)

Doctor/Clinic Code

Plan Partner Name (see back of choice form)

KA HN ←

Enter plan change reason code*.

PLAN PARTNER INFORMATION FOR:

305 Inland Empire Health Plan

KA KP Cal, LLC

355 Molina Healthcare Partner

HN Health Net Comm Solutions

Facility Site Review Compliance Department

The Facility Site Review Compliance Department provides one-to-one education and support.
21281 Burbank Blvd., Woodland Hills, CA 91367
Phone: (209) 943-4803

Fax: 1-877-779-0753
Facility.site.review@healthnet.com

Fraud Hotline

Suspected cases of health care fraud and abuse by providers or Members should be reported to the Health Net Fraud Hotline.
1-800-977-3565

Health Care Services

The Health Care Services Department conducts concurrent review of inpatient cases and coordinates coverage for patients under the care management program.
1-800-421-8578
Fax: 1-800-743-1655

Health Education

The Health Education Department improves the health of Medi-Cal Members through education, information and Member support.
650 E. Hospitality Lane, #200
San Bernardino, CA 92407
(818) 543-9072
1-800-804-6074
Fax: 1-800-628-2704

Hospital Notification Unit

Hospitals are required to contact the Health Net Hospital Notification Unit within twenty-four (24) hours or by the end of the next business day when any Health Net Member is admitted to the facility.
1-800-995-7890
Fax: 1-800-676-7969

Member Appeals and Grievances

Contract Relationships

Health Net handles the appeal and grievance process for counties for which Health Net is directly contracted with the Department of Health Care Services (DHCS). Health Net is *subcontracted* for Medi-Cal business in Riverside and San Bernardino counties and Molina is directly contracted with DHCS. Therefore, Molina processes all appeals and grievances in those counties. Health Net cooperates with Molina by providing information and as described in the contract between Molina and Health Net

Mental Health Services MHN Direct Services Care

MHN is Health Net's behavioral health subsidiary. The Customer Service Department is available to providers and their staff, Monday through Friday, 5:00 a.m. to 5:00 p.m., to assist with the referral process, Member eligibility and benefits, or to schedule a consultation with an MHN medical director/psychiatrist.
1-800-675-6110

MLTSS (Managed Long-Term Services and Supports)

Managed Long-Term Services and Supports (MLTSS) include a wide variety of services and supports that help Medi-Cal Members meet their daily needs for assistance and improve their quality of life. Medi-Cal MLTSS services are provided over an extended period, and include all of the following Medi-Cal covered benefits:

1) In-Home Support Services
2) Community-Based Adult Services
3) Multipurpose Senior Services Programs and,
4) Skilled Nursing Facility services and subacute services

For members delegated to Health Net in the Inland Empire (Riverside and San Bernardino), Health Net ensures that Members in need of Medi-Cal benefited LTC are placed in facilities that provide the level of care most appropriate to the Member's medical needs. The "facilities" include Skilled Nursing Facilities, Nursing Facilities, Subacute facilities, and Intermediate Care Facilities.

For all questions regarding LTC referrals and authorizations, or the check the status of a request, providers can contact the Health Net Medical Management, Non-Clinical Intake Team by telephone at 1-800-453-3033 or fax at 1-855-851-4563.

Pharmaceutical Services

Health Net's Pharmacy Benefit Manager administers Health Net's Medi-Cal Recommended Drug List (RDL) and medication prior authorization requests.
P.O. Box 419069
Rancho Cordova, CA 95741-9069
1-800-867-6564
Fax: 1-800-977-8226

PM 160 INF Forms

For information about completing and submitting PM 160 INF forms, refer to the Health Net provider website at provider.healthnet.com> *Provider Library > Operations Manuals*.
Once in the Medi-Cal operations manual, select *Public Programs >Child Health and Disability Prevention (CHDP) Program > PM 160 INF Form information*.

Electronic Submission of PM 160 INF Form

Providers may submit PM 160 INF forms electronically by logging in to the Health Net provider website at provider.healthnet.com and selecting *Submit PM 160 INF Form* under *Transactions*.

The electronic PM 160 INF form is completed the same as the hard copy version. Providers can download a copy of the PM 160 INF instructions by selecting the link provided on each page of the electronic form. There are four steps to completing the electronic form:

1. Enter Member name and client index number (CIN). Patient Information and Responsible Party Information fields automatically populate when this is entered
2. Record screening procedures performed and the outcome of each procedure
3. Record vital statistics and immunizations information
4. Document additional information, such as referrals to other providers, tobacco questions, eligibility information, and any problems or comments. Once complete, select *Submit*

Providers receive confirmation for each PM 160 INF form submitted. Providers must remember to print three (3) copies of the completed form and submit one to the local CHDP office, keep one in the Member's chart, and give one to the Member or Member's parent or legal guardian.

Manual Submission of PM 160 INF Form

Send completed PM 160 INF forms to the address indicated by the PPG.
Attn: CHDP Specialist
PO Box 419071, Rancho Cordova, CA 95741-9071
Fax: 1-866-684-7363

To order forms, use the fax number or call:
(916) 935-0165

The prepaid project codes (also known as Health Plan Codes (HPCs) are:
Riverside – 355
San Bernardino - 356

Provider Appeals Unit

Submit claims appeals to Health Net Medi-Cal Claims Appeals at the following address:
PO Box 419086, Rancho Cordova, CA 95741-9086

Provider Network Management

The Provider Network Management Department is the provider liaison to Health Net's administrative programs, including contracting, claims resolution, and on-site education and training.
(818) 543-9178

Provider Relations (Riverside and San Bernardino County)

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.
3131 Camino Del Rio North, Ste. 200
San Diego CA, 92108
Phone: 209-275-7906
Fax: 866-660-0464
HN_provider_relations@healthnet.com

Provider Services Center

The Medi-Cal Provider Services Center handles telephone and written inquiries from providers regarding claims, benefits, and provider grievances and appeals.
21281 Burbank Blvd. C-5, Woodland Hills, CA 91367
1-800-675-6110
Fax: 1-818-676-5387 or 1-800-281-2999
Email:

Eligibility and billing inquiries: hnmedi-cal.eligibility@healthnet.com

Claim status and denial inquiries: hnmedi-cal.claimsinquiry@healthnet.com

Capitated claims/nonpayment: hnmedi-cal.providerbilling@healthnet.com

Public Programs Department

Public programs administrators interact with public health departments and programs and work with participating providers and DHCS in administering public health programs and services.
1-800-526-1898

Quality Improvement Department

Contact the State Health Programs Quality Improvement Department for information on quality improvement projects for Health Net's Medi-Cal Members.
Cqi_dsm@healthnet.com

Transportation (NEMT and NMT)

Transportation services to and from medical appointments for medically necessary covered services are available to all Health Net delegated Medi-Cal Members in Riverside and San Bernardino counties.

Non-Medical Transportation (NMT)
Effective July 1, 2017, Health Net is providing non-medical transportation (NMT) to and from medical appointments for medically necessary covered services to all its Medi-Cal Members through LogistiCare Solutions, LLC.

Non-Emergency Medical Transportation (NEMT)
Health Net continues to provide non-emergency medical transportation (NEMT) for Health Net Members assigned to participating physician groups delegated for utilization management but not financially at risk for transportations services.

Any referral source (PPGs, hospitals, skilled nursing facilities, etc.) is required to contact LogistiCare to arrange for transportation services. Using transportation services from any provider other than LogistiCare may result in the denial of the claim for which you may be liable.

A Physician Certification Form (PCS form) is required for both NMT and NEMT services. LogistiCare will send a PCS form to physicians to indicate approval for level of service. Physicians can refer to the table below to contact LogistiCare to obtain a PCS form. For additional information about coverage requirement, refer to the provider operations manuals available in the Provider Library on the Health Net provider website at provider.healthnet.com.

SCHEDULING TRANSPORTATION SERVICES THROUGH LOGISITCARE

Providers should refer to the table below and contact LogistiCare to arrange for medically necessary or covered transportation services.

LogistiCare Transportation Services	
LogistiCare uses language-line interpreter services for all interpretation needs during reservations.	
STANDARD DAYS AND HOURS OF CUSTOMER SERVICE CENTER OPERATION FOR ROUTINE RESERVATIONS	Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific time (PT)
WEEKEND AND HOLIDAY SCHEDULE	Closed Saturday and Sunday Closed on the following national holidays: New Year's Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving, and Christmas
ROUTINE TRANSPORTATION REQUESTS	Requires a 5 business day notification.
URGENT TRIP AND HOSPITAL DISCHARGE REQUESTS	Advance notice is not required and transportation can be scheduled for the same day of service. For hospital discharge, it may take a transportation provider 1 to 4 hours to pick up a member, depending on provider availability.
HOURS OF OPERATION FOR URGENT AND SAME-DAY RESERVATIONS	Transportation assistance for trip recovery and after-hours hospital discharges is available 24 hours a day, 7 days a week
HOURS OF OPERATION FOR RIDE ASSISTANCE (*WHERE'S MY RIDE?* LINE) AND HOSPITAL DISCHARGES	Transportation assistance for trip recovery and after-hours hospital discharges is available 24 hours a day, 7 days a week
ROUTINE TRANSPORTATION APPOINTMENTS SCHEDULED FOR SATURDAY AND SUNDAY AND WEEKDAYS AFTER 5:00 P.M.	Allowed for regularly scheduled appointments to participating providers who routinely see patients during this time. Reservations for these trips are scheduled during regular reservation hours
TOLL-FREE TELEPHONE NUMBERS	Reservations: 1-855-253-6863 Ride assistance (*Where's My Ride?* line): 1-855-253-6863 Hearing impaired (TTY): 1-866-288-3133 Facility line: 1-866-529-2128 Facility fax: 1-877-601-0535
WEBSITE	http://facilityinfo.logisticare.com/cafacility Providers may use the LogistiCare website to schedule only routine transports with advance notice of 5 business days. Print an enrollment form from the LogistiCare website to sign up for this HIPAA-compliant service and return by fax to 1-877-601-0535

Vision

Health Net has partnered with Evolve Vision to provide vision services to Health Net Members. The PCP is the primary screener for ocular abnormalities requiring referral for a comprehensive eye examination. Comprehensive eye examinations performed by an optometrist or ophthalmologist are covered for all Medi-Cal Members. Providers should refer to the Health Net Provider Directory for a list of participating optometrists and ophthalmologists. Providers should contact the Health Net Medi-Cal Provider Services Center to obtain the most current directory.

For Health Net Delegated Members, Optical lenses are made by California Prison Industry Authority (CalPIA) optical laboratories and provided with cost through the optometrist's or ophthalmologist's office participating with Evolve Vision for covered vision services.

1.4 CONTACTS: RIVERSIDE COUNTY

Molina Healthcare of California
San Bernardino/Riverside Regional Office
(800) 232-9998
Send correspondence to:
550 E. Hospitality Ln. Ste. 100
San Bernardino, CA 92408

Attn: Provider Services

AIDS Waiver Agency
Inland AIDS Project
3756 Elizabeth Street
Riverside, CA 92506
(909) 784-2437 phone

Child Health and Disability Prevention (CHDP) Program
10769 Hole Ave.
Riverside, CA 92505
(951) 358-5481 phone
PM 160 County Code: 355

Communicable Disease Control
(951) 358-5107 phone

CPSP Perinatal Services
308 E. San Jacinto Ave.
Perris, CA 92570
(951) 210-1153 phone / (951) 210-1348 fax

Regional Center
(Riverside and San Bernardino County)
Inland Regional Center
1365 S. Waterman Ave.
San Bernardino, CA 92408
Mail:
PO Box 19037, San Bernardino, CA 92423
(909) 890-3000 phone

Riverside University Health System
4065 County Circle Drive
Riverside, CA 92503
(951) 358-5000 phone

Riverside University Health System-Behavioral Health
CARES (Community Access, Referral, Evaluation, and Support) Line
(800) 706-7500 phone / (800) 915-5512 TTY

Riverside University Health System Substance Abuse
SU CARES Line (800) 499-3008 phone

TB Control Program
Disease Control Branch
Health Administration Building
4065 County Circle Drive
Riverside, CA 92503
(951) 358-5107 phone

Women, Infant, & Children (WIC)
Banning: (800) 732-8805 phone
Riverside: (800) 455-4942 phone

1.5 CONTACTS: SACRAMENTO COUNTY

Molina Healthcare of California
Northern Regional Administration Office
(916) 561-8540
2180 Harvard St. Ste. 500
Sacramento, CA 95815

AIDS Waiver Agency
4640 Marconi Avenue, Suite 1
Sacramento, CA 95821-4316
(916) 979-7300 phone

Alcohol and Drug Treatment Services
Alcohol and Drug System of Care
(916) 874-9754 phone
The last assessment is conducted at 4:00 p.m.

Child Health and Disability Prevention (CHDP) Program
County Department of Health
9333 Tech Center Drive, #100
Sacramento, CA. 95826
(916) 875-7151 phone / (916) 875-6731 fax
PM 160 County Code: 130

CPSP Perinatal Services
9333 Tech Center Drive, Suite 800
Sacramento, CA 95826
(916) 876-7750 phone / (916) 875-6001 fax

Communicable Disease Control
7001-A East Parkway
Sacramento, CA 95823
(916) 875-5471 phone / (916) 875-4069 fax

HIV Prevention and Education
(916) 875-6022 phone

Regional Center
Alta California Regional Center
2241 Harvard Street, Suite 100
Sacramento, CA 95815
(916) 978-6400 phone

Sacramento County Behavioral Health Services
Grantland L. Johnson Center for Health and Human Services
7001-A East Parkway, Suite 400
Sacramento, CA 95823
(916) 875-7070 phone / (916) 875-6970 fax
Email: hhs-bhs@saccounty.net
Mental Health Access Team
(916) 875-1055 or toll free
(888) 881-4881

Sacramento County Public Health
(916) 875-5881 phone

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
Sacramento Department of Health and Human Services
2251 Florin Road #100
Sacramento, CA. 95822
(916) 427-5500 phone

TB Control Program
Primary Care Center, Chest Clinic
4600 Broadway
Sacramento, CA 95820
(916) 874-9670 phone

Women, Infant, & Children (WIC)
Sacramento: (916) 326-5830 or (916) 876-5000

1.6 CONTACTS: SAN BERNARDINO COUNTY

Molina Healthcare of California
San Bernardino/Riverside Regional Office
(800) 232-9998Send correspondence to:
550 E. Hospitality Ln. Ste. 100
San Bernardino, CA 92408
Attn: Provider Services

Calif. Children's Services (CCS) Program
150 E Holt Blvd, 3rd Floor, Ontario, CA 91762 (909) 458-1637phone / (909) 986-2970 fax

Child Health and Disability Prevention (CHDP) Program
120 Carousel Mall
San Bernardino CA 92415
(909) 387-6499 phone / (909) 387-6348 fax
PM 160 County Code: 356

Communicable Disease Control
351 N. Mountain View Avenue
San Bernardino, CA 92415
(800) 722-4794 phone / (909) 387-6377 fax

CPSP Perinatal Services
120 Carousel Mall
San Bernardino, CA 92415-0028
(909) 388-0104 phone / (909) 388-0462 fax

San Bernardino County Public Health
351 N. Mt. View Avenue
San Bernardino, CA 92415
(800) 782-4264 phone / (909) 387-6359 TTY

San Bernardino County Behavioral Health
303 E. Vanderbilt Way
San Bernardino, CA 92415
Member Services: 24/7 Access & Referral Helpline: 1 (888) 743-1478 or (909) 386-8256 phone

San Bernardino County Behavioral Health: Substance Use Disorder & Recovery
(909) 386-9740 or (800) 968-2636 Toll Free
(909) 387-7200 phone / (909) 387-7717 fax

Women, Infant, & Children (WIC)
San Bernardino: (855) 424-7942 phone

1.7 CONTACTS: SAN DIEGO COUNTY

Molina Healthcare of California
San Diego Regional Office
(858) 614-1580
9275 Sky Park Ct, Suite 400
San Diego, CA 92123

AIDS Waiver Agency
150 Valpreda Road, Suite 211
San Marcos, CA 92069
(760) 736-6725 phone

Calif. Children's Services (CCS) Program
County Department of Health
6160 Mission Gorge Road
San Diego CA. 92120
(619) 528-4000 phone / (619) 528-4087

Child Health and Disability Prevention (CHDP) Program
3851 Rosecrans Street
San Diego, CA. 92110
(619) 692-8808 phone / (619) 692-8827 fax
PM 160 County Code: 013
Mail: PO Box 85222, San Diego, CA 92186

Communicable Disease Control
(619) 692-8499 or (858) 565-5255 phone

CPSP Perinatal Services
3851 Rosecrans Street, Suite 522
San Diego CA 92110
(619) 542-4053 phone / (619) 542-4045 fax

Regional Center
4355 Ruffin Road, Suite 200
San Diego, CA. 92123-1648
(858) 576-2996 phone

San Diego Behavioral Health Services Health and Human Services Agency
County of San Diego
1600 Pacific Highway, Room 206
San Diego, CA 92101
(888) 724-7240 phone

San Diego County Public Health
(619) 531-5800 phone

Substance Use Disorder Services
Alcohol and Drug Services
1-888-724-7240 phone

TB Control Program
(619) 692-5565 phone

Women, Infant, & Children (WIC)
Chula Vista: (619) 426-7966
San Diego: (800) 500-6411
San Marcos: (760) 471-2743
SDSU: (888) 999-6897

2.0 ELIGIBILITY, ENROLLMENT, DISENROLLMENT

ELIGIBILITY FOR MANAGED CARE

Mandatory Aid Categories

Under the Geographic Managed Care (GMC) and Two-Plan Model, enrollment is mandatory for the following aid categories eligible for Medi-Cal without a share-of-cost:
- CalWorks - formerly Aid to Families with Dependent Children (AFDC)
- CalWorks - formerly Medically Needy, Family (AFDC)
- Medically Indigent Children
- Refugee/Entrant
- Public Assistance, Family

Voluntary Aid Categories

Beneficiaries who fall into these aid categories may enroll but are not required to do so:
- Public Assistance, Aged
- Public Assistance, Blind/Disabled
- Medically Needy, Aged (no share-of-cost)
- Medically Needy, Blind/Disabled (no share-of-cost)
- Medically Indigent Adult

Exemptions from Mandatory Enrollment

Medi-Cal beneficiaries meeting the following criteria are exempt from mandatory enrollment:
- Individuals with a complex or high-risk medical condition who are in an established treatment relationship with a provider(s)/practitioner(s) or who are not participating in the GMC or Two-Plan Model provider/practitioner network
- Children in Foster Care or the Adoptions Assistance Program*
- Native Americans, their household members, and other persons who qualify for services from an Indian Health Center*

Not Permitted to Enroll

Medi-Cal beneficiaries meeting the following criteria are not permitted to enroll under the GMC Program and Two-Plan Model:
- Individuals with the following other health coverage:
  - Kaiser HMO
  - CHAMPUS
  - Other HMO coded K, F, C, or P
  - Medicare HMO (unless it is also a Geographic Managed Care Plan, and the Department of Health Care Services allows this plan to enroll beneficiaries in both the contractor's Medicare HMO and Medi-Cal managed care plan)

* These individuals are exempt from mandatory enrollment, although if they wish to enroll, they may do so.

NEW MEMBERS

Molina Healthcare of California (MHC) receives EDI 834 Benefit Enrollment and Maintenance transactions from DHCS and weekly Health Care Options (HCO) data file. The data received from HCO is matched to the processed EDI 834 and stored in MHC's core operating system. This process creates a new Member file for eligibility purposes and production of Member identification cards. Each new Member receives an MHC Welcome Packet that includes an MHC identification card. This identification card will contain the name of the Member's Primary Care Practitioner (PCP). To identify a Member's assigned PCP, you may also refer to MHC's Interactive Voice Response system or the Plan's Member Services Department. The identification card issued by MHC is for Plan Identification only. Although the Member eligibility is verified at the time the card is issued, possession of the card does not guarantee eligibility. In case a Member has lost the identification card or his/her eligibility is in question, eligibility may be verified using one of the following options:

- MHC's Provider Portal (www.MolinaHealthcare.com)
- IPA/Medical Group Eligibility List file Molina Healthcare Interactive Voice Response at (888) 665-4621 MHC's Member Services Department at (888) 665- 4621

If the Member does not appear on the current eligibility roster, the Provider/Practitioner should contact MHC's Provider Services Department at (855) 322-4075.

At no time should a Member be denied services because his/her name does not appear on the eligibility roster. Please remember that a Member may access emergency services without prior authorization.

Remember, the card is for identification purposes only. Eligibility to receive services depends on verification from MHC. If a Member has questions that you are unable to answer, suggest a call to MHC's Member Services Department.

ELIGIBILITY VERIFICATION

Providers are encouraged to register and use the Molina's Provider Web-Portal as a primary method to check Member's eligibility information: www.MolinaHealthcare.com.

The MHC Interactive Voice Response (IVR) system notifies both Providers/Practitioners and Members of Member eligibility status and PCP assignment. The system has a dedicated phone line at (800) 357-0172 and is available twenty-four (24) hours a day, three-hundred-sixty-five (365) days a year. The system provides Members' last name, first name, date of birth, eligibility status, and PCP information, as well as IPA/Medical Group affiliation and subcontract health plan affiliation as applicable.

In the event that the IVR System is not working, Provider/Practitioner may verify eligibility directly with Molina's Member Services representative (888) 665-4621 from Monday through Friday, 7:00 a.m. to 7:00 p.m. Any calls made during non-business hours go directly to MHC's after hour service, with the same access to current Member eligibility status.

ELIGIBILITY LIST FILES

MHC distributes Eligibility reports monthly to provide information on Member enrollment in an IPA/Medical Group. The reports are generated the first week of each month and mid-month MHC Medi-Cal Members who have changed Providers/Practitioners by the 15th of a month will be in effect for the currently calendar month. Members who have changed Providers/Practitioners on or after the 16th of a month will be in effect the first day of the listed on the month following the next month

These files are secured, and password protected and can only be accessed by the IPA/Medical group designee that are identified as the recipient. For additional details of the IPA/Medical Group Eligibility List files, please contact your Provider Services representative.

If a Member arrives at a PCP's office to receive care, please verify the Member's eligibility through Molina's Provider Web-Portal, Eligibility List file or MHC Member Services. A Member must not be denied services because his/her name does not appear on the eligibility roster.

MEDI-CAL ENROLLMENT

Health Care Options (HCO) is responsible for providing Medi-Cal beneficiaries information pertaining to the benefits of health care services through a managed care plan. HCO also assists the beneficiary in making choice among the different managed care plans. HCO is responsible for assigning beneficiaries who fail to choose a health plan to a managed care plan within each beneficiary's county. HCO is responsible for the distribution of enrollment forms to beneficiaries as well as to the various managed care health plans. The health plans then distribute the forms to their prospective Members upon request. The health plans and their affiliated Providers/Practitioners are no longer allowed to submit the Medi-Cal Enrollment Forms on behalf of their patients. If beneficiaries have questions regarding the enrollment process, they should be directly referred to HCO at (800) 430-4263 Please visit DHCS website (www.DHCS.ca.gov) for additional information on Medi-Cal Enrollment.

PCP AUTO ASSIGNMENT

Upon initial enrollment, if the Member did not select a PCP, MHC will assign a PCP to the Member and mail out an ID card with the Welcome Packet indicating PCP assignment. The Welcome letter explains to the Member that they may select a different PCP if they are dissatisfied with the choice made for them. The letter also advises Members of the importance of scheduling an appointment with their PCP within the first ninety (90) days of initial enrollment.

The following criterion is followed when processing auto assignment of a PCP:

- The proximity of the provider/practitioner must be within ten (10) miles or thirty (30) minutes of Member's residence
- The Member's language preference
- The Member's age, gender, and special PCP needs (i.e., Pediatrician, Obstetrician, etc.)
- The existence of established relationships and family linkages
- MHC makes every attempt to assign Members to the PCP of their choice. MHC is limited to the information that is on the HCO data file, which is neither always complete nor correct

DISENROLLMENT PROCESS

Any Member of MHC may at any time, without cause, request to be disenrolled from the plan. The Member must contact HCO at (800) 430-4263. An HCO representative will mail a disenrollment form to the Member's residence. A Member with a mandatory aid code must simultaneously re-enroll into another managed care health plan. If the Member fails to select a health plan, HCO will automatically assign him/her to one. Members who have a voluntary aid code may elect to remain in the Medi-Cal Fee-for-Service program or select a new health plan.

Until the Member's disenrollment request is approved and processed by DHCS, MHC will be responsible for the Member's health care.

Disenrollment of a Member is mandatory under the following conditions:

- Member requests to be disenrolled
- Member loses Medi-Cal eligibility
- Member moves out of the Plan's approved service area
- Member's Medi-Cal aid code changes to an aid code not covered
- Member's enrollment violates the State's marketing and enrollment regulations
- Member requests disenrollment as a result of a Plan merger or reorganization
- Member is eligible for those carve-out services that require disenrollment. (See Additional Services or Carve-Out Services)

Members disenrolled because of any of the above conditions will be allowed to return to the Fee-for-Service Medi-Cal Program unless their Medi-Cal eligibility is a mandatory managed care aid code or eligibility is terminated by DHCS. MHC does not determine eligibility for the Medi-Cal program. DHCS allows for certain beneficiaries to remain in Fee-for-Service Medi-Cal as described above, under the Heading, Exemptions from Mandatory Enrollment. Such exemptions are granted by HCO and DHCS, not MHC. For more information, contact HCO at (800) 430-4263.

PROVIDER/PRACTITIONER PLAN INITIATED DISENROLLMENTS (PID)

A Provider/Practitioner may request to DHCS that a Plan Initiated Disenrollment (PID) be processed for any of its Members. However, the health plan is responsible to initiate the process with DHCS. All written communication letters sent to the Members must be prior approved by the Plan and/or DHCS.

The Provider/Practitioner contracted with MHC must make its requests in writing and forward such requests to MHC's Member Services Department, Attn: Member Services Director. These requests must include a detailed description of the circumstances prompting the Provider/Practitioner to initiate the request for disenrollment. Included should be any documentation and detailed description of corrective action taken by the Provider/Practitioner in an effort to resolve the matter. The detailed description should include:

- Statement of the specific issue
- Dates of occurrence
- Frequency of occurrence

Upon receipt of such request from the Provider/Practitioner, the Member Services Department Director or designee will make an effort to contact the Member to provide education and counseling. Member Services will involve a Case Manager to attempt to coordinate care. The Member may be transferred to another PCP within the plan. In every case, the Member is notified in writing of the intent to disenroll and given a thirty (30) day opportunity to appeal to the Member Services Department or DHCS fair hearing via telephone or in writing. At no time should the Provider/Practitioner contact the Member without approval of the Member Services Department Director or designee. The Member Services Department Director or designee will then review the request with the Plan's Medical Director and process a PID request to DHCS for approval. Once DHCS reviews the request; the Member is mailed a letter, via U.S. mail, notifying him/her of the outcome.

MHC is responsible to notify the Member via certified mail that the Plan has been notified of their behavior. The Member will be warned that further non-compliance may result in transferring the Member to an alternate Provider/Practitioner or termination of membership from the plan based on the severity of the issue. If the Member fails to comply and behavior is repeated, the Provider/Practitioner must immediately send documentation of repeated offense to MHC Member Services. The Provider/Practitioner is responsible for sending final documentation to the Plan. MHC must notify the Member again (second and final notification) in

writing via U.S. certified mail of MHC's intent to request a PID or transfer to an alternate Provider/Practitioner. The provider will receive a copy of the letter for their medical records.

A PID is evaluated on the severity and cause of the breakdown of the Provider/Practitioner/Member relationship. Below are examples of circumstances that could result in a PID. To initiate a PID, the documentation process outlined above must be followed.

DHCS will approve a request only if one or more of the following circumstances have occurred:

- The Member is repeatedly verbally abusive to Plan Providers/Practitioners, ancillary or administrative staff, or to other Plan Members
- The Member physically assaults a Plan Provider/Practitioner, staff member, or Plan member, or the Member threatens any individual with any type of weapon on the Plan premises. In such cases, appropriate charges must be brought against the Member, and a copy of the police report should be submitted along with the request
- The Member is disruptive to Provider/Practitioner operations in general with potential limitation of access to care by other patients
- The Member habitually uses non-contracted Providers/Practitioners for non-emergency services without prior authorization
- The Member has allowed the fraudulent use of his or her health plan identification card
- The Member refuses to transfer from a non-Plan hospital to a Plan hospital when it is medically safe to do so
- Other inappropriate use of out-of-plan services that result in degradation in the Plan's relations with community Providers/Practitioners thereby threatening the access of other Plan Members

A Member's failure to follow prescribed medical care treatment, including failure to keep established medical appointments, does not warrant a request for a PID unless MHC can demonstrate to DHCS that, as a result of such failure, the Plan or Provider/Practitioner is exposed to greater and unforeseeable risk. In this event, a temporary PID may be requested by the Plan and granted by DHCS.

Expedited Disenrollment Requests

The Plan may request for an expedited disenrollment for the following:

- **Continuity of Care** - If the treating Provider/Practitioner is not part of MHC's network of Providers/Practitioners, the Member may be eligible for disenrollment. The Member is only eligible for disenrollment within the first ninety (90) days of initial enrollment with MHC. A medical exemption form signed by the treating Provider/Practitioner and Member is required for processing
- **Incarceration** - The name of the facility and the date the Member entered the facility is required for processing
- **Resides Outside-of-the-Service Area** - The Member moved outside of the service area. The Member's new address and move date is required. The Member must report their change of address to their eligibility worker within ten (10) days. Failing to do so will result in delaying the disenrollment from MHC
- **Native American** - If the Member is a Native American the Member may be exempted from being in a health plan. A Non-Medical Exemption form must be completed by an Indian Health Service Provider/Practitioner. The form is required for processing
- **Major Organ Transplant** - The Member must be approved for a transplant and the Treatment Authorization Form (TAR) must be provided to MHC's Member Services Department for processing

All requests for expedited disenrollment's along with any required documentation must be submitted to Enrollment Supervisor via facsimile at (855) 248-7534 or US Mail. The Member may also initiate a request by

calling Member Services Department at (888) 665-4621. If you need copies of the exemption forms mentioned, please contact HCO at (800) 430-4263.

Molina Healthcare
Attn: Enrollment Supervisor
200 Oceangate, Suite 100
Long Beach, CA 90802
Fax: (855) 248-7534

Related Policies-For more information or a copy of the complete PID policy, contact MHC's Member Services Department at (888) 665-4621.

3.0 BENEFITS AND COVERED SERVICES

PRINCIPAL BENEFITS AND COVERAGES

The following benefits and services are available for prevention, diagnosis, and treatment of illness or injury (including ancillary services). Please refer to the Prior Authorization section of this manual for authorization requirements to understand benefits and service coverage according to contract and service area or contact Provider Services at (855) 322-4075.

- Provider/Practitioner Services
- Preventive Health Services
- Family Planning
- Maternity Care
- Hospital Services
- Outpatient Mental Health Services^
- Substance Use Disorder Preventive Services (AMSC)
- Behavioral Health Treatment
- Prescription Drugs and Medications
- Vision Services
- Laboratory X-ray, and Prescribed Services
- Cancer Clinical Trials
- Durable Medical Equipment
- Therapeutic Formulas
- Enteral Nutrition Products
- Diabetic Equipment and Supplies
- Long Term Services and Supports (LTSS)*
- Home Health Care
- Hospice Care
- Emergency Care
- Medical and Non-Medical Transportation

*In Sacramento and Imperial counties, Long-Term Care (LTC) coverage is limited to the month of admission and the following month. Members return to the Fee-for-Service Medi-Cal (FFS) program for continued LTC coverage after this period. To ensure continuity of care, the Provider/Practitioner will continue to provide and coordinate the care for potential LTC candidates until the Member is disenrolled from MHC.

In Los Angeles, San Diego, San Bernardino and Riverside counties, MHC is responsible for LTC coverage. Additional information can be found in the LTSS section.

For custodial authorization or outpatient services needed while in custodial level of care, please fax all requests to the Prior Authorization Department: at 800-811-4804.

For any questions regarding custodial authorization or services needed while in custodial level of care, please contact the MHC UM Prior Authorization Department at (844) 557-8434.

There are exceptions for the services noted with a caret. Please see the paragraph titled “Exceptions for Services Not Covered by Molina Healthcare or Regular Medi-Cal.”

PRINCIPAL EXCLUSIONS AND LIMITATIONS

The following benefits and services are excluded from coverage:

Services that are not covered by Molina Healthcare or Medi-Cal

These services will not be provided by MHC or Regular Medi-Cal (fee-for-service program):

- Experimental or investigational drug, device, or procedures (unless approved)
- Over the counter (OTC) drugs (unless approved)
- Cosmetic surgery, except when required to repair trauma or disease-related disfigurement
- Personal comfort or convenience items
- Private duty nurses (except when medically necessary)
- Elective circumcisions
- Chiropractic Services for Two Plan Model Counties (Riverside/San Bernardino only)
- Sports physicals required by school or recreational sport
- Completing forms for disability, Women, Infants, and Children's Supplemental Nutrition Program (WIC), or Department of Motor Vehicles (DMV)
- Audiology Services not performed/prescribed by a provider in a provider office
- Speech Therapy Services
- Podiatry Services
- Dental Services
- Services outside the United States, except Emergency services requiring hospitalization in Canada and Mexico
- Chiropractic Services for GMC Counties (San Diego and Sacramento only) - limited to excepted Members [this is not a benefit for Two Plan (Riverside/San Bernardino) Members – no exceptions]

There are exceptions for the services noted with a caret. Please see the section titled "Exceptions for Services Not Covered by Molina Healthcare or Regular Medi-Cal."

Excluded (Carve-Out) Services

Medi-Cal beneficiaries enrolled in a managed care plan obtain most of their benefits from their health plan. Medi-Cal services not covered by the plan are referred to as "excluded" or as "carve-out." These services can only be rendered by a Medi-Cal enrolled Provider/Practitioner and must be billed through the Medi-Cal Fee-for-Service (FFS) system. In most cases, beneficiaries remain enrolled in their health plan while receiving these excluded services. Coordination of carved out services is part of the role of the primary care provider. (Refer to the Basic Case Management section for more details). Below is a list of those excluded services that may be obtained while a beneficiary remains enrolled in a managed care plan.

- California Children's Services
- Mental Health
  - MHC does not cover hospital care and specialty mental health care. Medi-Cal FFS or the County Mental Health Department provides these services
- Alcohol and Drug Treatment
- Dental Services
- Directly Observed Therapy for TB
- Women, Infants, and Children Supplemental Food Program (WIC)
- Local Education Agency Services

Member Disenrolls from Managed Care in Order to Receive the Following Services

- Long-Term Care [approximately sixty (60) days after admission]*
- Major Organ Transplantation except Kidney and Cornea
- Medi-Cal Home and Community Based Waiver Programs

*In Sacramento and Imperial counties, Long-Term Care (LTC) coverage is limited to the month of admission and the following month. Members return to the Medi-Cal Fee-for-Service (FFS) program for continued LTC coverage after this period. To ensure continuity of care, the Provider/Practitioner will continue to provide and coordinate the care for potential LTC candidates until the Member is disenrolled from MHC. In Los Angeles, San Diego, San Bernardino and Riverside counties, Molina is responsible for LTC coverage. Additional information can be found in the LTSS section.

EXCEPTIONS FOR SERVICES NOT COVERED BY MOLINA HEALTHCARE OR REGULAR MEDI-CAL

Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009) added Section 14131.10 of the Welfare and Institutions Code (W&I Code) to exclude several optional benefits from coverage under the Medi-Cal Program for Members twenty-one (21) years and older, effective July 1, 2009. Please refer to the Medi-Cal Provider Manual on the Department of Health Care Services website for a description of optional benefit exclusions and exemption criteria.

MEDICAL AND NON-MEDICAL TRANSPORTATION

Member transportation is coordinated through MHC for all Members.

Emergency Medical Transportation

Emergency medical transportation is provided when necessary to obtain covered benefits when the Member's medical/physical condition is acute and severe, necessitating immediate diagnosis and treatment so as to prevent death or disability.

If a Member in a facility has a medical emergency requiring hospitalization, the attending Provider/Practitioner must arrange ambulance transportation by a licensed ambulance company to the nearest emergency room or dial 911 to obtain ambulance service.

Non-Emergency Medical Transportation (NEMT)

MHC provides ambulance, litter van, wheelchair van and air medical transportation services. These services are covered only when a Member's medical and physical condition is such that ordinary means of public or private transportation would be medically inappropriate. MHC ensures that the transportation coverage is limited to the lowest cost service available that is adequate for the Member's needs. Transportation coverage is also limited to the nearest Provider/Practitioner capable of meeting the needs of the Member. Providers/Practitioners must submit the Physician Certification Statement (PCS) form to the plan in order for NEMT transportation to be provided, in accordance with DHCS guidelines. The PCS form must be completed in its entirety, and include the following elements:

- Function Limitations Justification: Document the Member's limitations and provide specific physical and medical limitations that preclude the Member's ability to reasonably ambulate without assistance or be transported by public or private vehicles
- Dates of Service Needed: Provide start and end dates for NEMT services; for a maximum of twelve (12) months

- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).
- Physician Certification Statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested.

Members are instructed to contact Secure Transportation, the plan's contracted transportation vendor, at (844) 292-2688. It is recommended that request be made at least seventy-two (72) hours in advance of the service.

NEMT Modes of Transport and Criteria

Mode of Transport	Criteria
Ambulance	• Transfers between facilities for Members who require continuous intravenous medication, medical monitoring or observation • Transfers from an acute care facility to another acute care facility • Transport for Members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use) • Transport for Members with chronic conditions who require oxygen if monitoring is required
Litter Van: When the Member's medical and physical condition does not meet the need for NEMT ambulance services, but meets **both** of the following →	• Requires that the Member be transported in a prone or supine position, because the Member is incapable of sitting for the period of time needed to transport • Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance
Wheelchair Van: When the Member's medical and physical condition does not meet the need for litter van services, but meets **any** of the following →	• Renders the Member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport • Requires that the Member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation • Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance • Members with the following conditions qualify for wheelchair van transport: Members who suffer from severe mental confusion; Members with paraplegia; Dialysis recipients; Members with chronic conditions who require oxygen but do not require monitoring
Air transport: only provided under the following conditions →	• When transportation by air is necessary because of the Member's medical condition or because practical considerations render ground transportation not feasible

For more information regarding transportation, please contact Molina Healthcare Member Services at (888) 665-4621 for more information. TTY users dial 711.

Non-Emergency Non-Medical Transportation (NMT)

Non-Emergency non-medical transportation is available if Member is recovering from serious injury or medical procedure that prevents them from driving to medical appointment. They must have no other form of transportation available.

Non-Emergency non-medical transportation to medical services can be supplied by a passenger car, taxi cabs, or other forms of public/private transportation. Transportation must be arranged at least three (3) working days before appointment.

3.1 BENEFITS AND COVERED SERVICES: HEALTH EDUCATION

MOLINA HEALTHCARE HEALTH EDUCATION

Phone: (866) 891-2320 (Monday-Friday 8:30AM-5:30PM) **Fax:** (562) 901-1176

The provision of health education services is the responsibility of IPA affiliated medical groups under the Managed Medi-Cal contract. As Providers/Practitioners, you are in the best position to meet the many educational needs of MHC Members at the time of their medical visits. You are the most credible educator for your patients. However, MHC supports our providers/practitioners by making available many Health Education programs, materials and services that will be discussed below.

DHCS Health Education Contract Requirements for Managed Medi-Cal Members

To meet DHCS Managed Medi-Cal contract requirements for health education services, IPAs/Providers must make available to Members educational services in the following areas:

- **Appropriate use of health care services** – managed health care; preventive and primary health care; obstetrical care; health education services; and complementary and alternative care
- **Risk–reduction and healthy lifestyles** – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, physical activity; and parenting
- **Self-care and management of health conditions** – pregnancy; asthma; diabetes; and hypertension

All education must be documented in the Member's medical record. This information should become part of the Member's ongoing medical care as all team Members can reinforce new positive health behaviors. This documentation also becomes critical in the event of an audit by any regulatory organization.

Tobacco Prevention and Cessation Services

All providers are required to identify and track all tobacco use, both initially and annually. This must be performed by doing the following:

- Completing the individual Health Assessment, which includes the Individual Health Education Behavioral Assessment (IHEBA), for all new beneficiaries within 120 days of enrollment
- Annually assess tobacco use status for every beneficiary based on the SHA's periodicity schedule
- Ask tobacco users about their current tobacco use and document in their medical record at every visit

More information on the IHEBA and SHA can be found in the "Healthcare Services: Women's & Adult Health Services, Including Preventive Care" section of the manual.

All providers are also required to institute a tobacco user identification system to identify tobacco users in their primary care practice, per USPSTF recommendations. Among other things, a tobacco user identification system for providers may include:

- Adding tobacco use as a vital sign in the chart or Electronic Health Records
- Using International Classification of Diseases (ICD)-10 codes in the medical record to record tobacco use
- Placing a chart stamp or sticker on the chart when the beneficiary indicates he or she uses tobacco
- A recording in the SHA or other IHEBA
- A recording on the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM 160)

- Reviewing Nicotine Replacement Therapy (NRT) claims.

It is the intent of this requirement that providers not only assess tobacco use but report it to Molina, in order to more fully coordinate Molina Members' tobacco cessation treatment.

Services for Pregnant Tobacco Users

Because of the serious risk of smoking to the pregnant smoker and fetus, whenever possible, pregnant beneficiaries should be offered tailored, one-on-one counseling exceeding minimal advice to quit.
Providers are required to:

- Ask all pregnant beneficiaries if they use tobacco or are exposed to tobacco smoke
- Offer all pregnant beneficiaries who use tobacco at least one face-to-face tobacco cessation counseling session per quit attempt
- Refer pregnant beneficiaries who use tobacco to a tobacco cessation quit line, such as the California Smoker's Helpline
- Refer to the tobacco cessation guidelines by the American College of Obstetrics and Gynecology (ACOG) before prescribing tobacco cessation medications during pregnancy

Prevention of Tobacco Use in Children and Adolescents

Providers are required to:

- Provide interventions, including education or counseling, in an attempt to prevent initiation of tobacco use in school-aged children and adolescents. Services shall be provided in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance, as periodically updated

Provider training

Providers are strongly encouraged to refer to the "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update" for provider training on tobacco cessation treatments. This document informs and educates clinicians regarding effective strategies and approaches for providing tobacco cessation treatment for all populations, including specific recommendations for pregnant women.

When counseling beneficiaries, providers are encouraged to use the "5 A's" (Ask, Advise, Assess, Assist, and Arrange), the "5 R's" (Relevance, Risks, Rewards, Roadblocks, Repetition), or other validated behavior change models.

Please refer to the below links for more information on the "5 A's" and "5 R's":
http://www.improvingchroniccare.org/downloads/3.5_5_as_behaviior_change_model.pdf
http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5rs.html

Special Programs Provided by Molina Healthcare

To support our provider network, MHC makes available programs and services in many of the required areas. If you are an IPA/Medical Group affiliated Provider/Practitioner, please consult the table titled "Health Education Services" in the exhibit section to determine the remaining requirements that are your responsibility.

Health Management Programs

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

- Asthma (Breath with Ease Asthma Program)
- Depression (Building Brighter Days Adult Depression Management Program)
- Weight Management
- Smoking Cessation (CA Smokers' Helpline)
- Diabetes Prevention Program

To find out more information about the health management programs, please call Provider Services Department at **(855) 322-4075**.

Breathe with Ease^{SM} Program

Molina Healthcare provides an asthma health management program called breathe with ease^{SM}, designed to assist Members in understanding their disease. Molina Healthcare has a special interest in asthma, as it is the number one chronic diagnosis for our Members. This program was developed with the help of several community Providers with large asthma populations. The program educates the Member and family about asthma symptom identification and control. Our goal is to partner with you to strengthen asthma care in the community.

Building Brighter Days Adult Depression Management Program

The Building Brighter Days - Depression Management Program is a collaborative team approach comprised of health education, clinical case management and provider education. The overall goal is to provide better overall quality of life, quality of care and better clinical outcomes for Members who have a primary psychiatric diagnosis of major depressive disorder. This will be accomplished by providing disease-specific measurable goals for Members and their support systems that are also easily measured by Molina staff and by members. The Molina team works closely with contracted practitioners in the identification assessment and implementation of appropriate interventions for adults with depression. Molina's Building Brighter Days Program strives to improve outcomes through early identification, continual, rather than episodic, care and monitoring, and most importantly interventions focused on self-advocacy and empowerment of the Member.

Weight Management

Molina's Weight Management program is comprised of one-on-one telephonic education and coaching by a health educator to support the weight management needs of the Member. The Health Education staff work closely with the Member, providing education on nutrition, assessing the Member's readiness to lose weight, and supporting the Member throughout their participation in the Weight Management Program. The Health Education staff work closely with the Member's Provider to implement appropriate intervention(s) for Members participating in the program. The program consists of multi-departmental coordination of services for participating Members and uses various approved health education/information resources such as: Centers for Disease Control and Prevention, National Institute of Health and Clinical Care Advance system for health

information (i.e. Healthwise Knowledgebase). Health Education resources are intended to provide both general telephonic health education and targeted information based on the needs of the individual.

Smoking Cessation

MHC Members are eligible for Provider cessation counseling, medications as prescribed, referrals to group counseling or classes, and telephonic counseling. We refer to the California Smoker's Helpline for telephonic counseling. Providers may refer directly to the California Smoker's Helpline by using their online referral system. Members may call the Helpline directly at the following numbers:
English: 1-800-NO-BUTTS
Spanish: 1-800-45-NO-FUME
Vietnamese: 1-800-778-8440
Chinese: 1-800-838-8917
Korean: 1-800- 556-5564
Chew tobacco: 1-800-844-CHEW
TDD/TYY: 1-800-933-4TDD

PCPs can prescribe nicotine replacement therapy to use in conjunction with the behavior modification program by faxing a completed Medication Prior Authorization Request Form (only needed for certain NRTs) along with the prescription to **(866) 508-6445**. For a list of group counseling, support groups or classes in all counties of operation for referral by providers please visit Molina's provider website at: https://www.molinahealthcare.com/providers/ca/medicaid/forms/PDF/tobacco-cessation-group-counseling-and-classes.pdf.

Diabetes Prevention Program
Molina Healthcare offers the Diabetes Prevention Program (DPP) to eligible members. The DPP is an online lifestyle change program that focuses on member engagement and health outcomes and is recognized by the Centers for Disease Control and Prevention (CDC). It was developed to prevent type 2 diabetes and is designed for members who have been diagnosed with prediabetes or are at risk for type 2 diabetes. This program is not for members who already have diabetes. Trained coaches lead the program to help members change certain aspects of their lifestyle focusing on healthy eating, stress reduction, and physical activity to create long term changes and lasting results.

The DPP takes referrals from network providers, self-referring members, and Molina staff. Members will take a short online assessment to verify program eligibility. Please refer Molina members to the following website to enroll and participate in the program: http://www.yeshealth.com/molina.

Process for Referring an MHC Member to Health Management Services
- Obtain agreement for a referral to Health Management from the Member;
- Stress compliance as part of the Member's overall care plan;
- **Refer Member for only one condition at a time.** This will help the Member not feel overwhelmed;
- Complete the Molina Healthcare Health Education Referral Form. Select the correct referral form (IPA/Medical Group or Direct/SMO) (Available on MHC's website in the frequently used forms area);
- Fax Health Education Referral Form and supporting documentation to **(562) 901-1176**;
- Document referral in the Member's medical record;
- Reinforce key concepts and compliance with Member at follow-up office visits

ADDITIONAL HEALTH EDUCATION RESOURCES

Written Patient Education Materials

MHC has patient education materials in key subject areas such as Appropriate Use of Healthcare Services, Risk Reduction and Healthy Lifestyles, and Self-Care and Management of Health Conditions. The most appropriate setting for a Member to receive written literature is from his or her primary care practitioner (PCP) with a brief discussion. Health education materials are used to supplement the patient teaching that occurs in the provider offices, provide reinforcement for the telephonic counseling, or as stand-alone pieces that support self-care initiatives.

MHC recognizes the need for the availability of low literacy health education materials in the Member's preferred languages. We offer a variety of low literacy materials available in English, Spanish, and other languages as requested. Network physicians may download and print health education materials from the provider website to meet the needs of Molina Members at http://www.MolinaHealthcare.com/providers/ca/medicaid/comm/Pages/Health-Education-Materials.aspx. Members may also download and print health education materials in the topic area of interest from the Member website. These materials are provided at no cost to physicians or our Members. We will translate materials into other languages and alternative formats, at no cost to the provider or Member, as requested.

Specific Requirements for Serving Molina Healthcare's Medi-Cal-only SPD Members

MHC Members with low vision or who are blind should be offered materials in alternate formats including ***large font of at least eighteen (18)-point print, Braille or audio****. MHC's contracted providers/practitioners can request materials in alternative formats by contacting the Member and Provider Contact Center*

Member Newsletters

Molina produces newsletters such as the Guide to Accessing Quality Healthcare. The newsletters contain a variety of topics suggested by Members and the California Department of Health Care Services. Key Plan telephone numbers and resources are provided to assist Members in using their plan benefits appropriately. The contents are for information only and do not take the place of Provider/Practitioner advice. All newsletters are made available on the Molina website under Health and Wellness: https://www.molinahealthcare.com/members/ca/en-US/mem/medicaid/medical/resources/news/Pages/memnews.aspx. Additionally, the preventive health guidelines ("Grow and Stay Healthy") are posted on our website to keep families on track with obtaining recommended physical examinations and tests: https://www.molinahealthcare.com/providers/ca/medicaid/resource/Pages/guide_prevent.aspx.

Individual Medical Nutrition Therapy (Registered Dietitian "RD" services)

For directly contracted Providers/Practitioners, MHC will provide individual medical nutrition therapy for high-risk conditions with a Provider/Practitioner referral. Complete the Health Education Referral form and indicate risk condition. Attach recent lab results and progress notes to assist the RD in counseling the Member most appropriately. All documentation from the appointment with the RD will be sent back to the Provider/Practitioner for inclusion in the Member's medical record.

ADDITIONAL PCP RESPONSIBILITY

Individual Health Education Behavioral Risk Assessment "Staying Healthy Assessment"

All Providers/Practitioners of managed Medi-Cal Members must administer an Individual Health Education Behavioral Assessment (IHEBA). The Staying Healthy Assessment (SHA) is DHCS's IHEBA. This must be completed with new patients at their Initial Health Assessment within one-hundred-twenty (120) days of enrollment into the health plan and with existing Members at their next scheduled non-acute care visit (but no later than their next scheduled health screening visit). The SHA forms are available in many age categories and threshold languages. Assessments are to be completed by Members twelve (12) years of age and older and by parents of children eleven (11) years of age and younger while waiting for their medical visit. Providers/Practitioners must review the assessment, provide needed counseling or other intervention, document on the assessment, and file in the Member's medical record with other continuity of care forms. This assessment is reviewed with the Member or parent at least annually and is re-administered when the Member enters the next age category. MHC recommends that the adolescents complete the assessment annually as they change behaviors rapidly during this period.

All completed SHA forms for twelve to seventeen (12-17) year-olds should be placed under the "sensitive tab" in the medical record, preventing photocopying should parent/guardian request the record. This precaution protects the confidentiality of the minor's disclosures.

The SHA forms are available for download on MHC's website under Healthcare Providers and Forms (at the bottom of the page): https://www.molinahealthcare.com/providers/ca/medicaid/forms/Pages/fuf.aspx.

HEALTH PLAN OVERSIGHT (HEALTH EDUCATION AND QUALITY IMPROVEMENT MONITORS IPAS / MEDICAL GROUPS)

Medical Record Audits and Facility Reviews

Plan initiated medical record audits verify that services are documented in the Member's medical record. Facility reviewers check on availability of health education services and measure compliance with the implementation of the Staying Healthy Assessments (SHA).

Focused Studies

Quality Improvement executes studies using various indicators. Data from multiple sources may be used, including medical record review, pharmacy utilization, and preventive care utilization.

HEALTH EDUCATION SERVICES

Matrix distinguishing health education service to the IPA affiliated practitioners versus directly contracted practitioners.

Program/Service labeled "X" are MHC programs/services that are available to both directly contracted practitioners and IPA affiliated Practitioners.

HEALTH EDUCATION SERVICES	DIRECTLY CONTRACTED PRACTITIONERS	IPA-AFFILIATED PRACTITIONERS
Smoking Cessation Program	**X**	**X**
Breathe With Ease Asthma Program (two to fifty-six [2-56] years old) *	**X**	**X**
Member materials such as brochures, fact sheets, etc. (downloadable from our website) that practitioners can give to MHC Members during the office visit.	**X**	**X**
Staying Healthy Assessment (SHA) Forms in all age categories and threshold languages (downloadable from our website).	**X**	**X**
Community program referrals	**X**	**X**
Weight Management Program (eighteen [18] years old and above)	**X**	**X**
Education for any of the following: • Appropriate use of health care services • Risk-reduction and healthy lifestyles • Self-care and management of health conditions	**X**	**IPA Responsibility**
Referrals for MHC Member identified as needing Medical Nutrition Therapy for a specific health condition	**X**	**IPA Responsibility**

* These programs are not available to LA County Members but may be offered by their primary contracted health plans.

3.2 BENEFITS AND COVERED SERVICES: CULTURAL COMPETENCY AND LINGUSTIC SERVICES

Background

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

Additional information on cultural competency and linguistic services is available at www.MolinaHealthcare.com, from your local Provider Services Representative and by calling the Molina Member & Provider Services at (855) 322-4075.

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). This guidance is also in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, creed, ancestry, religion, language, age, marital status, physical or mental disability or sex. This includes gender identity, sexual orientation, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56 pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top sixteen (16) non-English languages (per APL 17-011) spoken in California to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

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

Affirmative action shall be taken to ensure that Members are provided Covered Services without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, except where medically indicated. For the purpose of this section, physical disability includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

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

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

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

Cultural Competency

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

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services or online web-based training modules.

Training modules, delivered through a variety of methods, include:
- Provider written communications and resource materials;
- Online training modules;
- On-site cultural competency provider training; and,
- Integration of cultural

Integrated Quality Improvement – Ensuring Access

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

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e. braille, audio, large print),, leading to better communication, understanding and Member satisfaction. Online materials found on www.MolinaHealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

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

Program and Policy Review Guidelines

Molina conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity and language data from:
    - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership
    - Contracted Providers to assess gaps in network demographics
- We revalidate data at least annually
- Review local geographic population demographics and trends derived from publicly available sources (Community Needs Assessment)
- Review applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network
- Collection of data and reporting for the Diversity of Membership HEDIS measure
- Determination of threshold languages annually and processes in place to provide Members with vital information in threshold languages
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services
- Comparison with selected measures such as those in Healthy People 2020

24-Hour Access to Interpreter Services

Providers may request qualified telephonic interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at **(888) 665-4621**.

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or minor to interpret.

Molina offers qualified face-to-face interpreter services to providers and members at medical appointments based on complex medical cases such as medical or surgical procedures or tests, end-of-life care, cancer/oncology care, organ transplants, behavioral health/psychiatric appointments, initial physical therapy, hearing loss appointments, complex specialty care, and others as directed by a medical director. Call Molina's Member & Provider Contact Center toll free at (888) 665-4621 to submit a request. Requests should be made 3-5 days in advance of an appointment. **Documentation**

As a contracted Molina Provider, your responsibilities for documenting Member language services/needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic member lists that are sent to you each month by Molina
- Document all Member requests for interpreter services

- Document who provided the interpreter service. Information should include the interpreter's name, operator code, and vendor
- Document all counseling and treatment done using interpreter services
- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after being notified of his or her right to have a qualified interpreter at no cost

Members who are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to the Member & Provider Contact Center, Quality, Healthcare Services and all other health plan functions.

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

Molina will provide face-to-face service delivery for ASL to support our Members who are deaf and hard of hearing. Call Molina's Member & Provider Contact Center toll free at **(888) 665-4621** to submit a request. Requests should be made 3-5 days in advance of an appointment.

Nurse Advice Line

Molina provides twenty-four (24) hours/seven (7) days a week Nurse Advice Services for Members. The Nurse Advice Line provides access to twenty-four (24) hour access to interpretive services. Members may call Molina's Nurse Advice Line directly, English line at [888] 275-8750 or Spanish line at [866] 648-3537, or for assistance in other languages. The Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

4.0 PROVIDER RESPONSIBILITIES

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina Medi-Cal website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). This guidance is also in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Affirmative action shall be taken to ensure that Members are provided Covered Services without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, except where medically indicated. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

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

Section 1557 Investigations

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

Molina Healthcare
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802
Toll Free: (866) 606-3889
TTY/TDD: 711
On-Line: https://MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Facilities, Equipment and Personnel

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

Screening and Enrollment

All Medi-Cal Providers are required to complete the Medi-Cal fee-for-service provider screening and enrollment process through the DHCS enrollment portal in order to participate in Molina's Medi-Cal managed care program.

New Providers will not be accepted into Molina's Medi-Cal network if they are not actively enrolled through the DHCS screening and enrollment process.

DHCS' standardized application form(s) when applying for participation in the Medi-Cal program can be found on the DHCS website:
http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx

Providers may check the status of their enrollment on the California Health and Human Services Open Data Portal by visiting: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

More information regarding this requirement is available in APL 17-019 on the DHCS website.

Provider Data Accuracy and Validation

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

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. MHC is required to publish and maintain accurate provider directories in accordance with SB 137 and Health and Safety Code Section 1367.27. Invalid information can negatively impact Member access to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

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

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

Please visit our Provider Online Directory at https://providersearch.MolinaHealthcare.com to validate and correct most of your information. A convenient Provider web form can be found on the POD and additionally

on the Provider Portal at https://provider.MolinaHealthcare.com. Or notify your Provider Services Representative if your information needs to be updated or corrected.

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

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

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools.

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

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

Any providers entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for Molina's Provider Portal within thirty (30) days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers) (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain an National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at www.MolinaHealthcare.com.

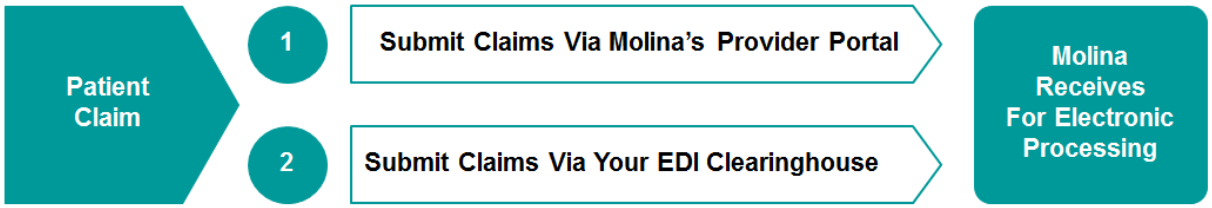
Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:
- Electronic Claims Submission Options
- Electronic Payment (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)
- Provider Portal

Electronic Claims Submission Requirement
Molina requires Participating Providers to submit claims electronically. Electronic claims submission provides significant benefits to the Provider including:
- Promotes HIPAA compliance
- Helps to reduce operational costs associated with paper claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery.

- Reduces Claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminates mailing time and enabling Claims to reach Molina faster.

Molina offers the following electronic Claims submission options:
- Submit Claims directly to Molina Healthcare of California via the Provider Portal. See our Provider Portal Quick Reference Guide https://provider.MolinaHealthcare.com or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 38333 refer to our website www.MolinaHealthcare.com for additional information.



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

Provider Portal Claims submitting benefits include:
- Add attachments to previously submitted claims
- Submit corrected Claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim
- Ability to Save incomplete/un-submitted Claims
- Create/Manage Claim Templates

For more information on EDI Claims submission, see the Claims and Encounter Data section of this Provider Manual.

Electronic Payment (EFT/ERA) Requirement

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

Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: www.MolinaHealthcare.com.

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

Provider Portal

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

- View benefits, covered services and Member Health record
- View Roster of Molina members for PCP(s)
- Claims Functions
  - Professional and Institutional Claims (individual or multiple claims)
  - Receive notification of Claims status change
  - Correct Claims
  - Void Claims
  - Add attachments to previously submitted claims
  - Check Claims status
  - Export Claims reports
  - Create and Manage Claim Templates
  - Open Saved Claims
- Prior Authorizations/Service Requests
  - Create and submit Service/Prior Authorization Requests
  - Check status of Service/Authorization Requests
  - Receive notification of change in status of Service/Authorization Requests
  - Create Service Request/Authorizations Templates
- View HEDIS® Scores and compare to national benchmarks
- Appeals
  - Create and submit a Claim Appeal
  - Add Appeal attachments to Appeal
  - Receive Email Confirmation

Third Party Billers can access and utilize all Claim Functions. Third Party Billers no longer have to phone in to get Claim updates and to make changes. All Claim functionalities are now available for Third Party Billers online at Molina's Provider Portal.

Balance Billing

Providers contracted with Molina cannot bill the Member for any Covered Services beyond applicable copayments, deductibles, or coinsurance. . The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Balance billing a Molina Member for services covered by Molina is prohibited. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

For additional information please refer to the Compliance and Claims and Compensation sections of this Provider Manual.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials (such as Member Handbooks/Member Evidence of Coverage documents).

Member Information and Marketing

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

Member Eligibility Verification

Possession of a Molina Medi-Cal ID Card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services. For additional information please refer to the Eligibility, Enrollment, Disenrollment section of this Manual.

Healthcare Services (Utilization Management and Case Management)
Providers are required to participate in and comply with Molina's Utilization Management and Care Management programs, including all policies and procedures regarding Molina's facility admission, prior authorization, and Medical Necessity review determination procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services. Clinical documentation necessary to complete medical review and decision making is to be submitted to Molina through electronic channels such as the Provider Portal. Clinical documentation can be attached as a file and submitted securely through the Provider Portal. Please see the Healthcare Services section of the Manual for additional details about these and other Healthcare Services programs.

In Office Laboratory Tests

Molina's policies allow only certain lab tests to be performed in a physician's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full-service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the physician's office is found on the Molina website at www.MolinaHealthcare.com.

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory (https://providersearch.MolinaHealthcare.com/). For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient services centers, please reach out to the In-Network Laboratory Provider.

Specimen collection is allowed in a physician's office and shall be compensated in accordance with your agreement with Molina and applicable State and Federal billing and payment rules and regulations.

Claims for tests performed in the physician office, but not on Molina's list of allowed in-office laboratory tests will be denied.

Referrals

A referral is necessary When a Provider determines Medically Necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals. Information is to be exchanged between the PCP and Specialist to coordinate care of the patient to ensure continuity of care. Providers need to document in the patient's medical record any referrals that are made. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina Medi-Cal, except in the case of Emergency Services. In the case of urgent and Emergency Services, Providers may direct Members to any appropriate service including but not limited to primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out of network Provider; Prior authorization will be required from Molina except in the case of Emergency Services. For additional information please refer to the Healthcare Services section of this Provider Manual.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a prior authorization.

Treatment Alternatives and Communication with Members

Molina endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Pharmacy Program

Providers are required to adhere to Molina's drug formularies and prescription policies. For additional information please refer to the Pharmacy section of this Provider Manual.

Participation in Quality Programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews
- Delivery of Patient Care Information

For additional information please refer to the Quality section of this Manual.

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that its contracted Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. For additional information, please refer to the Compliance section of this Provider Manual.

Participation in Grievance and Appeals Programs

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

For additional information please refer to the Appeals and Grievances/Complaints section of this Manual.

Participation in Credentialing

Providers are required to participate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable accreditation. This includes providing prompt responses to Molina's requests for information related to the credentialing or re-credentialing process.

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

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

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegation Policies and Delegated Services Addendum and this Provider Manual. Please see the Delegation section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

5.0 QUALITY IMPROVEMENT: ACCESSIBILITY OF SERVICES

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality Department toll free at (800) 526-8196, ext. 126137or fax (562) 499-6185

The address for mail requests is:

Molina Healthcare of California
Quality Department
200 Oceangate, Suite 100
Long Beach, CA 90802
This Provider Manual contains excerpts from the Molina Quality Improvement Program. For a complete copy of Molina's Quality Improvement Program, you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

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

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

- Have a Quality Improvement Program in place;
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during Potential Quality of Care and/or Critical Incident investigations; and,
- Allow access to Molina Quality personnel for site and medical record review processes

Patient Safety Program

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

Quality of Care

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

- Surgery on the wrong body part
- Surgery on the wrong patient

- Wrong surgery on a patient.

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

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. PCPs should maintain the following components:

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

Medical Record Keeping Practices

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

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

Content

Providers must remain consistent in their practices with Molina's medical record documentation guidelines. Medical records are maintained and should include the following information:

- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact;
- Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted
- Person or entity providing medical interpretation is identified
- Legible signatures and credentials of Provider and other staff members within a paper chart;
- All Providers who participate in the Member's care;
- Information about services delivered by these Providers;
- A problem list that describes the Member's medical and behavioral health conditions;
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Allergies and adverse reactions (or notation that none are known);

- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- Treatment plans that are consistent with diagnosis;
- A working diagnosis that is recorded with the clinical findings;
- Pertinent history for the presenting problem;
- Pertinent physical exam for the presenting problem;
- Lab and other diagnostic tests that are ordered as appropriate by the practitioner;
- Clear and thorough progress notes that state the intent for all ordered services and treatments;
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate;
- Notes from consultants if applicable;
- Up-to-date immunization records and documentation of appropriate history;
- All staff and Provider notes are signed physically or electronically with either name or initials;
- All entries are dated;
- All abnormal lab/imaging results show explicit follow up plan(s);
- All ancillary services reports;
- Documentation of all emergency care provided in any setting;
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report;
- Labor and Delivery Record for any child seen since birth; and
- A signed document stating with whom protected health information may be shared

Organization

- The medical record is legible to someone other than the writer
- Each patient has an individual record
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information
- A release document for each Member authorizing Molina to release medial information for facilitation of medical care

Retrieval

- The medical record is available to Provider at each Encounter
- The medical record is available to Molina for purposes of Quality Improvement
- The medical record is available to any governmental agency or any appropriate State and Federal authority having jurisdiction and the External Quality Review Organization upon request
- The medical record is available to the Member upon their request
- The medical record is available to the Member upon their request
- A storage system for inactive Member medical records which allows retrieval within twenty four (24) hours, is consistent with State and Federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than 10 (ten) years
- An established and functional data recovery procedure in the event of data loss

Confidentiality

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

- Ensure that medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas
- Maintain records and information in an accurate and timely manner
- Ensure timely access by Members to the records and information that pertain to them
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health an enrollment information
- Medical Records are protected from unauthorized access
- Access to computerized confidential information is restricted
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information
- Education and training for all staff on handling and maintaining protected health care information

Additional information on medical records is available from your local Molina Quality department toll free at (800) 526-8196, ext. 126137 See also the Compliance Section of this Provider Manual for additional information regarding HIPAA.

Access to Care

Molina Healthcare of California maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs (adult and pediatric) and participating specialist (to include OB/GYN, behavioral health providers, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on ninety percent (90%) availability for Emergency Services and ninety percent (90%) or greater for all other services (these goals may vary by plan). The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to Members.

Appointments with the Primary Care Practitioner (PCP)

Members are instructed through their member handbook to call their PCP to schedule appointments for routine/non-urgent care, preventive care and urgent/emergency care visits. The PCP is expected to ensure timely access to MHC members. If the need for specialty care arises, the PCP is responsible for coordinating all services that fall out of the scope of the PCP’s practice.

Standards of Accessibility

Access standards have been developed to ensure that all health care services are provided in a timely manner, however, the waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health care professional providing triage or screening services, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and documented in the relevant patient medical record that a longer waiting time will not have a detrimental impact on the health of enrollee.

These standards are based on regulatory and accreditation standards. MHC monitors compliance to these standards. All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted:

Type of Care and Service	Molina Healthcare Standards
Emergency Care	Immediately
PCP Urgent Care without prior authorization	Within forty-eight (48) hours of the request.
PCP Urgent Care with prior authorization	Within ninety-six (96) hours of the request.
PCP Routine or Non-Urgent Care Appointments	Within ten (10) business days of the request.
PCP Adult Preventive Care	Within twenty (20) business days of the request.
Specialist Urgent Care without prior authorization	Within forty-eight (48) hours of the request.
Specialist Urgent Care with prior authorization	Within ninety-six (96) hours of the request.
Specialist Routine or Non-Urgent Care	Within fifteen (15) business days of the request.
Urgent Care with a Behavioral Health Provider without prior authorization	Within forty-eight (48) hours of the request.
Urgent Care requiring prior authorization with a Behavioral Health Provider	Within ninety-six (96) hours of the request.
Routine or Non-Urgent Care Appointments with a Behavioral Health Provider	Within < ten (10) working days of the request.
Behavioral Health Non-life-threatening emergency	Within < six (6) hours of the request.
Routine or Non-Urgent Care Appointment with a Non-Physician Mental Health Provider	Within ten (10) working days of the request.
Routine or Non-Urgent Care Appointment for Ancillary Services	Within fifteen (15) working days of the request.
Children's Preventive Period Health Assessments (Well-Child Preventive Care) Appointments	Within seven (7) working days of the request.
After Hours Care	24 hours/day; 7 day/week availability

Type of Care and Service	Molina Healthcare Standards
Initial Health Assessment for a New Members (under eighteen (18) months of age)	Within one-hundred-twenty (120) days of the enrollment.
Initial Health Assessment for a New Members (over eighteen (18) months of age)	Within one-hundred-twenty (120) days of the enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP).
Maternity Care Appointments for First Prenatal Care	Within two (2) weeks of the request.
Office Telephone Answer Time (during office hours)	Within forty-five (45) seconds of call.
Office Response Time for Returning Member Calls (during office hours)	Within same working day of call.
Office Wait Time to be Seen by Physician (for a scheduled appointment)	Should not exceed thirty (30) minutes from the appointment time.

After-Hour Instruction for Life-Threatening Emergency (when office is closed)	Life-threatening emergency instruction should state: "If this is a life-threatening emergency, hang up and dial 911."
Physician Response Time to After-Hour Phone Message, Calls and/or Pages	Within thirty (30) minutes of call, message and/or page. A clear instruction on how to contact the physician or the designee (on-call physician) must be provided for Members.

If your office is unable to offer members appointments within the above standards, please contact member services (888)-665-4621.

Additional information on appointment access standards is available from your local Molina Quality functional area at 888-562-5442.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 30 minutes from the appointment time. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours Care and Emergencies

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour telephone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room. After-hour answering service or recorded message must provide a clear instruction on how to reach the physician or the designee (on-call physician) during after business hours. Physician or the designee must respond to urgent after-hours phone calls, messages, and/or pages within thirty (30) minutes.

Primary Care Office Hours

Generally, office hours are from 9:00 a.m. to 5:00 p.m. However, the Provider/Practitioner has flexibility to maintain his/her own reasonable and regular office hours. All primary care sites are required to post their regular office hours and be available to the members at least twenty (20) hours a week at the site. Answer time for a live person in the office to converse with a Member caller is within forty-five (45) seconds of the call during office hours. Response time for returning Member calls during office hours is within the same business day of the call. Office wait time to be seen by the physician for a scheduled appointment should not exceed thirty (30) minutes from the appointment time.

Urgent and Emergency Care at the Primary Care Practitioner's Office

The facility must have procedures in place to enable access to emergency services twenty-four (24) hours a day, seven (7) days a week. The facility staff needs to be knowledgeable about emergency procedures and be capable of coordinating emergency services. The recommended equipment for required emergency procedures needs to be easily accessible.

The emergency inventory list needs to be posted with drug expiration dates. Examples of emergency drugs are epinephrine and Benadryl. Oxygen needs to be secured, full, and equipped with a flow meter. The mask and Cannula need to be attached. Oral airways and ambo bags appropriate for patient population need to be

available. *(Refer to DHCS Facility checklist, Physician Facility Reviews).* If there is need for Basic Life Support or Emergency Medical Services (EMS), dial 911.

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language translation;
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and,
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit his/her practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If a PCP chooses to close his/her panel to new Members, Molina must receive thirty (30) days advance written notice from the Provider.

Facility Physical Access for the Disabled

MHC ensures that participating PCPs provide physical access for members with a disability and comply with the Americans with Disabilities Act (ADA) of 1990. Physical access should include availability of ramps, elevators, modified restrooms, designated parking spaces close to the facility, and drinking water provisions. If any physical barriers to disabled accessibility exist, MHC will discuss potential resolution with the Provider/Practitioner or the contracted IPA/Medical Group. Access for members with a disability are assessed during the PCP facility site review or Specialist physical access audit conducted by MHC.

Women's Health Access

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

Additional information on access to care is available under the Resources tab on the Molinahealthcare.com website.

Monitoring Access for Compliance with Standards

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

Provider network adherence to access standards is monitored via the following mechanisms:
1. Provider access studies – Provider office assessment of appointment availability, and after-hours access
2. Member complaint data – assessment of Member complaints related to access to care
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors Member complaints and appeals/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:
- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space

Physical Accessibility

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

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

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

Administration & Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per physician
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice
- At least one (1) CPR certified employee is available
- Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with ten (10) or more employees
- A container for sharps is located in each room where injections are given
- Labeled containers, policies, and contracts evidence hazardous waste management
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked
- A CLIA waiver is displayed when the appropriate lab work is run in the office
- Prescription pads are not kept in exam rooms
- Narcotics are locked, preferably double locked. Medication and sample access is restricted
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates
- Drug refrigerator temperatures are documented daily

Advance Directives (Patient Self-Determination Act)

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

Advance Directives are a written choice for health care. There are three (3) types of Advance Directives:

- **Durable Power of Attorney for Health Care**: allows an agent to be appointed to carry out health care decisions
- **Living Will**: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration
- **Guardian Appointment**: allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary

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

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

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

Members who would like more information are instructed to contact Member Services or are directed to the Caring Connections website at http://www.caringinfo.org/stateaddownload for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

Molina network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. Molina will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an Advance Directive. CMS Law gives Members the right to file a complaint with Molina or the State survey and certification agency if the Member is dissatisfied with Molina's handling of Advance Directives and/or if a Provider fails to comply with Advance Directives instructions.

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

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

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

Well Child/Adolescent Visits

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

- comprehensive health and developmental history;
- nutritional assessment;
- height and weight and growth charting;
- comprehensive unclothed physical examination;

- appropriate immunizations;
- laboratory procedures, including lead blood level assessment appropriate for age and risk factors;
- periodic developmental and behavioral screening;
- vision and hearing tests;
- dental assessment and services; and,
- health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention);

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

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

Monitoring for Compliance with Standards

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

TIMELY ACCESS TO CARE: SENSITIVE AND CONFIDENTIAL SERVICES FOR ADOLESCENTS AND ADULTS

Sensitive Services means those services related to:
- Sexual Assault
- Drug or alcohol abuse for children twelve (12) years of age or older
- Pregnancy
- Family Planning
- Sexually transmitted diseases for children twelve (12) years of age or older
- Abortion services
- HIV testing/counseling
- Mental Health Services
- Health Education Services

The following is a brief guide on providing access to Members for these sensitive areas.

Timely Access to Services and Treatment Consent

Members under the age of twelve (12) years require parental or guardian consent for obtaining services in the areas of sexually transmitted diseases or drug/alcohol abuse. Minors under the age of twelve (12) years seeking

abortion services are subject to State and Federal law. Those age twelve (12) and over can obtain any and all of the above services by signing the Authorization for Treatment form. Timely access is required by Providers/Practitioners for members seeking the sensitive/confidential medical services for family planning and/or sexually transmitted diseases, HIV testing/counseling, as well as for confidential referrals for treatment of drug and/or alcohol abuse.

Family Planning Services

To enhance coordination of care, PCPs are encouraged to refer Members to MHC Providers/ Practitioners for family planning. Members, however, do not require prior authorization from their PCP to seek family planning services. This freedom of choice provision is the result of Federal legislation.

Privacy and Security of Protected Health Information

Member and patient Protected Health Information (PHI) should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider/Practitioner may use and disclose PHI for their own treatment, payment and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. In addition, Providers/Practitioners must implement and maintain appropriate administrative, physical, and technical safeguards to protect the confidentiality of medical records and other PHI. Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. In general, most California healthcare Providers/Practitioners are subject to the following laws and regulations pertaining to privacy of health information:

- Federal Laws and Regulations
  - HIPAA
  - Medicare and Medicaid laws
- California Laws and Regulations
  - Confidentiality of Medical Information Act (CMIA)
  - Patient Access to Health Records Act (PAHRA)

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program (QIP). The Quality Improvement Program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management

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

Care Management

Molina's Care Management Program involves collaborative processes aimed at meeting an individual's health needs, promoting quality of life, and obtaining best possible care outcomes to meet the Member's needs so they receive the right care, at the right time, and at the right setting. Molina Healthcare Management includes Health Management (HM) and Case Management (CM) programs. Members may qualify for HM or CM based on

confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services. For additional information please see the Care Management heading in the Healthcare Services section of this Provider Manual.

Clinical Practice Guidelines

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

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Obesity
- Detoxification and Substance Abuse
- Opioid
- Sickle Cell Disease

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through Provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina website. Individual Providers or Members may request copies from the local Molina Quality Department at (800) 526-8196, ext. 126137.

Preventive Health Guidelines

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

- Perinatal/Prenatal Care
- Care for children up to twenty-four (24) months old
- Care for children two to nineteen (2-19) years old
- Care for adults twenty to sixty-four (20-64) years old
- Care for adults sixty-five (65) years and older
- Immunization schedules for children and adolescents
- Immunization schedules for adults

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to Providers via www.MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

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

Measurement of Clinical and Service Quality

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

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

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

Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

Molina's most recent results can be obtained from your local Molina Quality functional area at (800) 526-8196, ext. 126137or by visiting our website at www.MolinaHealthcare.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)

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

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is the tool used by Molina to summarize member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Healthcare and Getting Needed

Prescription Drugs. The CAHPS® survey is administered annually in the spring to randomly selected Members by a NCQA certified vendor.

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

Behavioral Health Survey

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

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on member experience with health care providers and health plans, MHC conducts a Provider Satisfaction Survey annually. The results from this survey are very important to MHC's, as this is one of the primary methods used to identify improvement areas pertaining to the MHC Provider Network. The survey results have helped establish improvement activities relating to MHC's specialty network, inter-provider communications, and pharmacy authorizations. This survey is fielded to a random sample of providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

What Can Providers Do?

- Ensure patients are up to date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology;
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed;
- Check that staff is properly coding all services provided; and,
- Be sure patients understand what they need to do

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit Molina's website and click on Providers. There is a variety of resources, including:

- HEDIS® CPT/CMS-approved diagnostic and procedural code sheets
- A current list of HEDIS® and CAHPS® Star Ratings measures

Effectiveness of Quality Improvement Initiatives

MHC monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods. In addition to the methods described above, MHC also compiles complaint and appeals data as well as on requests for out-of-network services to determine opportunities for service improvements.

Benefits and Services

The PCP should encourage Members to seek family planning services from Providers/Practitioners within MHC. This process will help to coordinate care and maintain continuity, supporting better health outcomes. Members have the right to access family planning services in a timely manner without need of prior authorization. Members need to access medical care based on the nature of their medical problem. Members may request a referral for drug and/or alcohol treatment programs. Please refer to Healthcare Services Section: Additional Services or Carve-out Services for further details and a list of benefits of the drug and alcohol program. Members will receive obstetrical services according to the Pregnancy and Maternal Care policy found in Compliance Section: Women's and Adult Health Services, Including Preventive Care. Members may receive family planning services from in plan or out of plan Providers/Practitioners as outlined in Compliance Section.

EMERGENCY CARE

Emergency Care

Emergency Services means those services needed to evaluate or stabilize an Emergency Medical Condition. Emergency Medical Condition means a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part

Emergency services using the prudent layperson definition or that meet Title 22 criteria for an emergency, do not require MHC prior authorization. In accordance with California Department of Health Care Services' policies and current law, members presenting to an emergency room facility may be triaged by the emergency room staff, and MHC will pay the Medical Screening Exam fee.

Notification Requirements

Emergency Department Support Unit (EDSU)

While the member is in the Emergency Room, please **fax all clinical records to our dedicated fax number at (877) 665-4625**. This fax number is used exclusively for members currently in the ER, to help expedite requests and assist with discharge planning.

Molina Healthcare's Emergency Department Support Unit will collaborate with you to provide assistance to ensure our members receive the care they need, when they need it.
The EDSU is a dedicated team, available twenty-four (24) hours a day, seven (7) days a week to provide support by:

- Assisting you in determining appropriate level of placement using established clinical guidelines
- Issuing authorizations necessary, for admission, or home health
- Coordinating transportation services
- Involving a Hospitalist or On-Call Medical Director for any Peer to Peer reviews needed
- Working with pharmacy to coordinate medications or infusions as needed
- Obtaining SNF placement if clinically indicated

- Coordinating placement into Case Management with Molina when appropriate
- Beginning the process of discharge planning and next day follow up with a primary care provider if indicated

Molina is excited to partner with you as we continue to provide quality service and care to our Members. **Call (844) 966-5462 to speak to an EDSU representative.**

Any emergency service resulting in an inpatient admission requires MHC notification and authorization within twenty-four (24) hours (or the next business day) of the admission. Furthermore, "Out of Area" and/or non-contracted emergency service Providers/Practitioners are required to notify MHC when the Member's condition is deemed stable for follow up care in MHC's service area, at a contracted facility. MHC adheres to the regulations set forth in Title 28, California Code of Regulations, Chapter 3, Section 1300.71.4, Emergency Medical Condition and Post Stabilization Responsibilities for Medically Necessary Health Care Services.

Fax Medi-Cal clinical documentation to: (866) 553-9263

After hours, weekends and holidays, please call: **Phone: (844) 9-MOLINA (844) 966-5462**

Emergency Room Discharge and After-Care

Aftercare instructions should be documented in the emergency facility medical record and communicated to the patient, parent, or guardian. Discharge from the emergency facility is performed on the order of a Provider/Practitioner.

Urgent Care

Direct and Molina Medical Group's Contracted Urgent Care Providers/Practitioners may obtain authorization for *urgent care* services by contacting the MHC Utilization Management Department. Telephone assistance for members and Providers/Practitioners is available twenty-four (24) hours a day, seven (7) days a week through MHC's Nurse Advice Program.

For transfer requests and discharge planning authorizations, after hours, weekends and holidays, please call: **(844) 9-MOLINA (844) 966-5462**

NURSE ADVICE PROGRAM

MHC provides twenty-four (24) hour Nurse Advice access for members and Providers/Practitioners. Licensed Registered Nurses perform telephone assessment of the member's complaints, provide telephone triage utilizing standardized guidelines which are reviewed and approved by the Nurse Advice Medical Director, and provide advice within the scope of their Registered Nurse license. Only licensed Registered Nurses offer advice regarding the member's medical condition and make referrals to appropriate level of care for treatment in accordance with established standards of practice. MHC Nurse Advice does not employ or allow Licensed Vocational Nurses to provide telephone triage/advice.

The goals of the Nurse Advice program are to:
- Advise and refer Members to appropriate level of care in a timely manner
- Coordinate the Member's care with the PCP
- Educate Members on health issues
- Assist in identifying Members who might benefit from additional case management services from MHC

The Nurse Advice programs are available to Members and Providers/Practitioners twenty-four (24) hour a day by calling: **(888) 275-8750 English (866) 648-3537 Spanish**
A tracking mechanism overseen by MHC is in place to follow up on the disposition of the Member as indicated, i.e. inpatient admission, urgent care or emergency care level treatment, need for specialty care, and office follow-up. This system is also responsible for ensuring notification to the PCP or IPA/Medical Group regarding members in need of follow-up care.

6.0 MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER BENEFITS

Health care professionals contracted with the State of California's Medi-Cal Program are obligated to provide member services in accordance with standards as to frequency, access, and medical office policies and procedures. The following gives a brief overview of these obligations.

Physicians from the following categories are eligible to be a Primary Care Physician (PCP); Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology (OB/GYN), and Pediatricians. PCPs may self-restrict their practice by age or sex. Molina Healthcare of California (MHC) may restrict member assignment to a PCP by age or sex (e.g., OB/GYN may be restricted to adult women, Pediatricians to children and adolescents).

PCPs must be able to provide the full range of preventative and acute health care and Comprehensive Medical Case Management services for all members assigned to them.

PCP Scope of Services Requirements

PCPs are required to provide the following services to Members assigned to them:

- Detect, diagnose, and effectively manage common symptoms and physical signs
- Treat and manage common acute and chronic medical conditions
- Perform ambulatory diagnostic and treatment procedures (injections, aspirations, splints, minor suturing, etc.)
- An Initial Health Assessment (IHA) within one-hundred-twenty (120) days of a member's enrollment or within periodicity timelines established by the American Academy of Pediatrics for ages two and younger, whichever is less which consists of a history and physical examination and an age appropriate Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic, dental and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered by the MHC Medi-Cal managed care benefit (e.g. carved out and linked services)
- Foster health promotion and disease prevention (age specific screening, health assessment and health maintenance activities, health education and promotion, including healthy lifestyle changes, etc.)
- Provide Comprehensive Medical Case Management (refer to community resources and available supplemental programs, coordinate care with specialists, etc.). Refer to specialists, other providers, and facilities appropriately to member care needs
- Follow required procedures for specialist, diagnostic, or service referral as promulgated by IPA/Medical Group and/or MHC

Specific Requirements for Serving Molina Healthcare's Medi-Cal-only SPD Members

Follow coordination of care instructions as described in the Utilization Management section of this Manual (CONTINUITY OF MEMBER CARE).

MOLINA MEMBER RIGHTS AND RESPONSIBILITIES

This document explains the rights of MHC's Medi-Cal Members, as stated verbatim as in the Member's Evidence of Coverage (EOC) Guide. Providers/Practitioners and their office staff are encouraged to be familiar with this document, post it in their office (poster provided by MHC), and are expected to abide by these rights. MHC's Member rights and responsibilities statement is as follows:

What are My Rights and Responsibilities as a Molina Healthcare Member?
These rights and responsibilities are posted in doctors' offices and on the Molina website: www.MolinaHealthcare.com.

Your Rights
You have the right to:

- Be treated with respect and recognition of your dignity by everyone who works with Molina.
- Get information about Molina, our providers, our doctors, our services and Members' rights and responsibilities
- Choose your "main" doctor from Molina's network (This doctor is called your Primary Care Doctor or personal doctor)
- Be informed about your health. If you have an illness, you have the right to be told about all treatment options regardless of cost or benefit coverage. You have the right to have all your questions about your health answered
- Help make decisions about your health care. You have the right to refuse medical treatment
- You have a right to Privacy. Molina keeps your medical records private.*
- See your medical record including the results of your Initial Health Assessment (IHA).
- You also have the right to get a copy of and correct your medical record where legally ok.*
- Complain about Molina or your care. You can call, fax, e-mail or write to Molina Member Services
- Appeal Molina's decisions
- You have the right to have someone speak for you during your grievance
- Ask for a State Fair Hearing by calling toll-free 1 (800) 952-5253. You also have the right to get information on how to get an expedited State Fair hearing quickly
- Disenroll from Molina. (Leave the Molina Health Plan)
- Ask for a second opinion about your health condition
- Ask for someone outside Molina to look into therapies that are Experimental or being done as part of exploration
- Decide in advance how you want to be cared for in case you have a life-threatening illness or injury
- Get interpreter services on a twenty-four (24) hour basis at no cost to you. This service will help you to talk with your doctor or Molina if you prefer to speak a language other than English
- Not be asked to bring a minor, friend, or family member with you to act as your interpreter
- Get information about Molina, your providers, or your health in the language you prefer. (You have the right to request information in printed form translated into the language you prefer)
- Ask for and get materials in other formats such as larger size print or at least eighteen (18)-point font, audio, and Braille upon request. We will get you the materials in a timely fashion appropriate for the format being requested, and in accordance with State laws
- Get a copy of Molina's list of approved drugs (drug formulary) on request
- Submit a grievance if you do not get medically needed drugs or a seventy-two (72) hour supply through the Molina Pharmacy Network after an Emergency visit at one of Molina's contracted hospitals
- Have access to family planning services, Federally Qualified Health Centers (FQHCs), Indian Health Services Facilities, Sexually Transmitted Disease (STD) services, and Emergency services outside of Molina's network according to federal laws. You do not need to get Molina's approval first

- Get minor consent services
- Not to be treated poorly by Molina, your doctors, or the Department of Health Care Services (DHCS) for acting on any of these rights
- Make recommendations about Molina's Member rights and responsibilities policies
- Be free from controls or isolation used to pressure, punish or seek revenge
- File a grievance or complaint if you believe your language needs were not met by Molina

*Subject to State and Federal laws

Your Responsibilities

You have the responsibility to:
- Learn and ask questions about your health benefits. If you have a question about your benefits, call toll-free at 1 (888) 665-4621. If you are deaf or hard of hearing, dial 711 for the California Relay Service
- Give information to your doctor, provider, or Molina that is needed to care for you
- Be active in decisions about your health care
- Follow the care plans and instructions for you that you have agreed on with your doctor(s)
- Build and keep a strong patient-doctor relationship. Cooperate with your doctor and staff. Keep appointments and be on time. If you are going to be late or cannot keep your appointment, call your doctor's office
- Give your Molina and state card when getting medical care. Do not give your card to others
- Let Molina or the state know about any fraud or wrongdoing. The Molina Alert Line is available twenty-four (24) hours, seven (7) days a week. To report an issue by telephone, call toll-free at (866) 606-3889
- Understand your health problems and participate in developing mutually agreed-upon treatment goals as you are able

Be Active In Your Healthcare

Plan Ahead:
- Schedule your appointments at a good time for you
- Ask for your appointment at a time when the office is least busy if you are worried about waiting too long
- Keep a list of questions you want to ask your doctor
- Refill your prescription before you run out of medicine

Make the Most of Doctor Visits
- Ask your doctor questions
- Ask about possible side effects of any drugs prescribed
- Tell your doctor if you are drinking any teas or taking herbs. Also tell your doctor about any vitamins or over-the-counter drugs you are using
- Visit your doctor when you are sick. Try to give your doctor as much information as you can.
- Tell your doctor if you are getting worse or if your symptoms are staying about the same
- Tell your doctor if you have you taken anything

If you would like more information, please call Molina's Member Services Department toll-free at 1 (888) 665-4621, Monday through Friday, between 7:00a.m. and 7:00p.m. If you are deaf or hard of hearing, dial 711 for the California Relay Service. TTY users dial 711.

MEMBER CONFIDENTIALITY

According to MHC's Medi-Cal Member Rights, members have the right to full consideration of their privacy concerning their medical care program. They are also entitled to confidential treatment of Member communications and records.

Case discussion, consultation, examination, Medi-Cal eligibility, and treatments are confidential and should be conducted with discretion. Member Protected Health Information (PHI) should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and the California Civil Code.

Office Procedure

All participating Providers/Practitioners must implement and maintain office procedures that will guard against disclosure of any PHI to unauthorized persons. These procedures should include at least the following elements:

- Written authorization obtained from the member or his/her legal representative, before medical records or other PHI is disclosed to a third party for a purpose not otherwise permitted or required under applicable Federal or State laws
- All signed authorizations for the use or disclosure of PHI must be carefully reviewed to verify that the authorization is valid and meets the requirements of applicable Federal and State law
- Each medical record and other PHI should be reviewed prior to making it available to anyone other than the Member or legal personal representative of the Member
- Only the portion of the medical record and other PHI specified in the authorization should be made available to the requester and should be separated from the remainder of the Member's medical records

Confidential Information

Confidential information also refers to any identifiable information about a member's character, conduct, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. More than the medical record constitutes, conversations, whether in a formal or informal setting, email, faxes, and letters are other potential sources of confidential member information.

Member confidentiality must be maintained at all times when providing health care services and during claims processing.

HIPAA Security & Submitting PHI/Medical Records to MHC

Providers are expected to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers should recognize that identity and medical theft is a rapidly growing problem in the healthcare industry and that patients trust their health care providers to keep their most sensitive information private and confidential.

MEMBER SATISFACTION SURVEY

MHC, or the State of California, conducts an annual satisfaction survey of its Medi-Cal Members. The National Committee for Quality Assurance (NCQA) Consumer Assessment of Health Plans Survey (CAHPS) is

conducted annually. NCQA translates the survey into English and Spanish only. It is not available in other languages. MRMIB (Managed Risk Medical Insurance Board) conducts an annual survey similar to CAHPS.

The purpose of the surveys is to gather information from members regarding their perception of the health plan, their health care, Providers/Practitioners, access to care, and health plan customer service. The data is used to identify systemic issues that need to be addressed. The annual survey results are communicated in the MHC physician newsletter.

7.0 APPEALS AND GRIEVANCES/COMPLAINTS

GRIEVANCES AND APPEALS

What to do if you receive a:

- Pre-service or prior authorization denial for lack of information: Resubmit the request within 30 days of denial date, to UM with the UM requested additional information
- Pre-service or prior authorization denial for lack of medical necessity, failure to meet criteria, or non-benefit: by contacting the MHC Member Services Department at (888) 665-4621
- Post-service or retrospective authorization denial: Appeal on behalf of the member by contacting the MHC Member Services Department at (888) 665-4621. A request for retrospective review must be submitted to MHC within sixty (60) days of the service being provided
- Payment denial for any reason except for an unclean claim: Appeal your payment denial within three hundred sixty-five (365) days using the dispute resolution process
- Non-payment for an unclean claim: Submit a clean claim within the noted timeframe and with the information that is requested in the remit message

Grievances and Appeals

This section addresses the identification, review, and resolution process for four (4) distinct topics:

- Provider/Practitioner Appeal (related to an authorization determination)
- Provider Disputes-Title 28, CCR, Section 1300.71.38 (related to provider claims appeals)
- Member Appeals (related to an authorization determination)
- Member Grievance [related to a Potential Quality of Care (PQOC) issue]

More information regarding PQOCs may be obtained by contacting MHC's Quality Improvement Department at (800) 526-8196, ext. 126137.

PROVIDER Claim Disputes- THE "APPEALS PROCESS"

A Provider/Practitioner grievance or complaint is described in Title 22, California Code of Regulations (CCR), as a written entry into the appeals process. Molina maintains two (2) types of appeals:

- Appeals regarding non-payment or processing of claims known as Provider Disputes

  A Provider/Practitioner of medical services may submit to Molina an appeal concerning the modification or denial of a requested service or the payment processing or non-payment of a claim by the Plan. Molina will comply with the requirements specified in Section 56262, of Title 22 of the CCR, and Title 28, CCR, Section 1300.71.38.

Claims Settlement Practices and Provider Dispute Resolution.

Appeals regarding modifications or denial of a pre-service request are considered Member appeals

PROVIDER DISPUTES

A Provider Dispute is defined as a written notice prepared by a provider that:

- Challenges, appeals, or requests reconsideration of a claim that has been denied, adjusted, or contested
- Challenges MHC's request for reimbursement for an overpayment of a claim

- Seeks resolution of a billing determination or other contractual dispute

For claims with dates of service in 2004 or after, all provider disputes require the submission of a Provider Dispute Resolution Request Form or a Letter of Explanation, which serves as a written first level appeal by the provider. For paper submission, MHC will acknowledge the receipt of the dispute within fifteen (15) working days and within two (2) days for electronic submissions. If additional information is needed from the provider, MHC has forty-five (45) working days to request necessary additional information. Once notified in writing, the provider has thirty (30) working days to submit additional information or the claim dispute will be closed by MHC.
Providers may dispute by submitting and completing a Provider Dispute Resolution Request Form within three hundred sixty-five (365) days from the last date of action on the issue. A written dispute form must include the provider name, identification number, and contact information, date of service, claim number, explanation for the dispute and all required documentation or proof to support the dispute. Disputes with incomplete information and missing required documentation will not be processed. Molina allows two resubmissions of a claim dispute.

How to Submit Provider Disputes:
Method 1: Molina Provider Portal (most preferred method):
- Log onto Molina's Provider Portal at: https://provider.molinahealthcare.com/
- Search and identify adjudicated claim and submit a dispute/appeal.
- Complete required information on the portal and upload required documents or proof to support the dispute.

Method 2: Fax to (562) 499-0633

Method 3: Mail to:

Molina Healthcare of California

Attn: Provider Dispute Resolution Unit
P.O. Box 22722
Long Beach, CA 90801

Provider Claim Disputes/Appeals Involving Shared Risk Capitated IPAs/Medical Groups

If an appeal involves a Member who is assigned to a Primary Care Practitioner (PCP) or IPA/Medical Group under a shared-risk capitated compensation agreement, Molina will delegate the first level of claim dispute/appeal to the IPA/Medical Group. Molina does not delegate the second level dispute/appeals. However, Molina will make the final determination on all claim disputes/appeals received from Providers/Practitioners. All first disputes/appeals should be mailed directly to the participating IPA/Medical Group. All first disputes/appeals received by Molina will be forwarded to the IPA/Medical Group upon receipt. The IPA/Medical Group will review the appeal and make an initial determination within fifteen (15) days of receipt of the appeal.

If the decision is to overturn the original claim denial, the IPA/Medical Group will respond to the Provider/ Practitioner and pay the claim. If the determination is to continue to uphold the denial, the IPA/Medical Group will then forward the first level claim dispute/appeal to Molina or its affiliated health plan for a second level dispute/appeal determination. If Molina upholds the denial, the Provider/Practitioner will be notified of the second level dispute/appeal decision at that time.

Balance Billing

MHC prohibits Providers/Practitioners from balance-billing a Member when the denial disputed is upheld. The Provider/Practitioner is expected to adjust off the balance owed if the denial is upheld in the appeals process.

MEMBER APPEALS

A Provider/Practitioner on behalf of a member may appeal a Utilization Management decision to deny or modify a requested service.

Member Appeals Process

If the Member or Provider/Practitioner on behalf of a Member is dissatisfied with an adverse authorization decision, he or she may initiate an appeal by telephone, fax, in writing, or on MHC's website, E-mail, or mail within sixty (60) calendar days after the Member's receipt of the denial or modification letter. Providers/Practitioners may refer members to MHC's website for additional information on how to file a Member grievance. Contact the department noted below, Monday through Friday between 7:00 am and 7:00 pm:

Molina Healthcare of California
Attn: Member Appeals and Grievance Department
200 Oceangate, Suite 100
Long Beach, CA 90802
(888) 665-4621
TTY users call: 711

Fax: (562) 499-0757
www.MolinaHealthcare.com

Standard (30-day) and Expedited (72-hour) Appeal Processes

Health plans have thirty (30) days to process a standard appeal. In some cases, members have the right to an expedited, seventy-two (72) hour appeal. Members can get a faster, expedited appeal if the member's health or ability to function could be seriously harmed by waiting for a standard appeal. If a member requests an expedited appeal, the health plan will evaluate the member's request and medical condition to determine if the appeal qualifies as an expedited, seventy-two (72) hour appeal. If not, the appeal will be processed within the standard thirty (30) days.

(The following sections indicated with an asterisk were extracted verbatim from the Medi-Cal Program Evidence of Coverage Guide for Providers/Practitioners to understand Independent Medical Review as explained to the members.)

INDEPENDENT MEDICAL REVIEW (IMR)

If you want an IMR, you must first file an appeal with your health plan. If you do not hear from your health plan within thirty (30) days, or if you are unhappy with your health plan's decision, then you may then request an IMR. You must ask for an IMR within one-hundred-eighty (180) days from the date of the "Notice of Appeal Resolution" letter.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-888-665-4621, TTY users call: 711 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-4662219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Website www.dmhc.ca.govhas complaint forms, IMR application forms, and instructions online.

Department of Managed Healthcare Services (DMHC) Assistance

STATE HEARING

If you want a State Hearing, you must ask for one within **120 days** from the date of the "Notice of Appeal Resolution" letter. You can ask for a State Hearing by phone or in writing:

- By phone: Call **1-800-952-5253**. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.
- In writing: Fill out a State Hearing form or send a letter to:
  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430
- Be sure to include your name, address, telephone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.
- After you ask for a State Hearing, it could take up to ninety (90) days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within three (3) working days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to ninety (90) days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an **"expedited hearing"** and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself. Or, someone like a relative, friend, advocate, doctor, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an "authorized representative."

External Independent Review

Experimental and investigational therapies may be denied when determined not to be medically necessary. However, California law entitles you to request and obtain an external independent review of that coverage decision through the independent medical review (IMR) process administered by the Department of Managed Health Care (DMHC) if your physician certifies that you have a life-threatening or seriously debilitating condition and further certifies that standard therapies have not been effective or do not exist with

respect to your condition, or there is no more beneficial therapy than the therapy proposed. If experimental and investigational therapies are denied, we will notify you within five (5) days of your right to request and obtain an external independent review of that decision by an entity accredited by the State of California and you may contact MHC at (888) 665-4621 Monday through Friday, 7:00 a.m. to 7:00 p.m. for information on this subject.

External independent review of a denial of experimental or investigational therapies will be completed within thirty (30) days of your request for review. However, if your physician determines that delay in the proposed therapy would be harmful if not promptly initiated, the external independent review may be expedited to provide a determination within seven (7) days of your request for expedited review.

You will be eligible to participate in MHC's external independent review system to examine a coverage decision regarding experimental and investigational therapies if you meet all of the following eligibility criteria:

1. You have either:
    A. A life-threatening condition, which includes either (1) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or (2) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival; or
    B. A seriously debilitating condition, which means diseases or conditions that cause major irreversible morbidity; and
2. Your physician certifies that you have a condition, as defined in paragraph (1) above, for which standard therapies have not been effective in improving your condition, would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by MHC than the therapy proposed pursuant to paragraph (3) below; and
3. Either:
    A. Your physician, who is under contract with or employed by MHC, has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to you than any available standard therapies, or
    B. You, or your physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in subdivision (d) of Health and Safety Code Section 1370.4, is likely to be more beneficial for you than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require MHC to pay for the services of a nonparticipating physician provided pursuant to this subdivision, that are not otherwise covered pursuant to MHC contract; and you have been denied coverage by MHC for a drug, device, procedure or other therapy recommended or requested pursuant to paragraph (3) above; and
4. The specific drug, device, procedure or other therapy recommended pursuant to paragraph (3) above would be a covered service, except for MHC's determination that the therapy is experimental or investigational.

Please note that you will have the right to submit evidence in support of your request for external independent review. You should also be aware that the external independent review system does not replace MHC's grievance process. Rather, the external independent review system is available in addition to MHC's grievance process.

Department of Health Care Services (DHCS) Assistance

The California Department of Health Care Services (DHCS) is available to provide assistance in investigating and resolving any complaints or grievances you may have regarding your care and services. If you wish to use the services of the DHCS to address your concerns, complaints, or grievances, please call the Medi-Cal Managed Care Ombudsman toll-free at (888) 452-8609, Monday through Friday, between 8:00 a.m. and 5:00 p.m. or dial 711 for TTY assistance.

State Regulations Available

State regulations, including those covering state hearings, are available at the local office of the County Welfare Department.

Authorized Representative

Members can represent themselves at the state hearing. They can also be represented by a friend, attorney, or any other person, but are expected to arrange for the representative themselves. Members can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response Unit (800) 952-5253.

MEMBER GRIEVANCE

The Department of Managed Health Care (DMHC) has amended the California Knox-Keene Health Care Service Plan Act pertaining to health plan member grievance procedures. Under this amendment, health plans are required to distribute the Plan's Member Grievance Procedures and Member Grievance/Complaint Forms to participating Providers/Practitioners.

Potential Quality of Care Issue (PQOC)

MHC recognizes that PQOCs may be identified through a multitude of inputs internally and externally, including Provider/Practitioner grievances or complaints and member grievances or complaints. For this reason, MHC's Quality Improvement Program includes input from both Provider Services and Member Services to identify both individual or incident specific PQOCs, as well as identifying specific trends.

Member Grievance System

MHC Members' grievances are addressed through MHC's internal grievance process. A Member grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by MHC to make an authorized decision. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. MHC will investigate Member grievances, attempt to resolve the concerns, and take action as appropriate resolutions and findings are considered confidential and are privileged under California law. A Member must not be discriminated against because he/she has filed a Member grievance.

Member Grievance Submission

Member grievances may be submitted to MHC verbally, via email, on the MHC website, or in writing. Members or the Provider/Practitioner on behalf of the member may call the MHC Member Services Department for assistance in lodging a grievance. Members may obtain a complaint form from their Primary Care Practitioner's (PCP's) office, the MHC website, or they may call the MHC Member Services Department to receive these forms. Once the Member grievance is received by the Member Services Department, the grievance is submitted to the appropriate departmental contact for investigation.

MHC will provide the Member with written notification acknowledging the Member grievance within five (5) working days of its receipt. The Member will be informed in writing of the proposed resolution or outcome of the grievance within thirty (30) days.

It is important to note that a Member grievance may be a potential quality of care or service issue and PCPs, as well as their office staff, should be ready to assist a Member with needed information. As a PCP, you must have MHC grievance forms in your office conveniently located for your Members or they can also be found on the MHC website. If you need to order grievance forms, please contact MHC's Provider Services Department at (855) 322-4075.

Member complaints may include, but are not limited to:

- Excessive waiting time in a Provider/Practitioner's office
- Inappropriate behavior and/or demeanor (PCP's/Office Staff's)
- Denied services. Clinical grievance subject to member/Provider/Practitioner appeal of the UM decision and expedited appeal of the UM decision
- Inadequacy of the facilities, including appearance
- Any problem that the member is having with MHC or their IPA/Medical Group, contracted Providers/Practitioners
- Members billed for covered services

8.0 HEALTHCARE SERVICES: UTILIZATION MANAGEMENT

Introduction

Healthcare Services is comprised of Utilization Management and Care Management departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides care management services to Members using processes designed to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina utilization management program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, medical necessity review, and restrictions on the use of out-of-network Providers. (866)814-2221 or (866) 553-9263

Utilization Management (UM)

Molina's UM Department is designed to provide comprehensive health care management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service. Molina works in partnership with Members and Providers to promote a seamless delivery of health care services. The UM team works closely with the Care Management team to ensure Members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. Molina's UM program ensures appropriate and effective utilization of services by managing benefits effectively and efficiently to ensure appropriate use of health care services .

- Identifying the review criteria, information sources, and processes that are used to review for medical necessity and appropriateness of the requested items and services
- Coordinating, directing, and monitoring the quality and cost effectiveness of utilization practice patterns of Providers to identify over and under service utilization
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness
- Reviewing processes to ensure care is safe and accessible
- Ensuring that qualified health care professionals perform all components of the UM/CM processes while providing timely responses to Member appeals and grievances
- Ensuring that UM decision tools are appropriately applied in determining medical necessity decisions
- Identifying and assessing the need for Care Management through early identification of high or low service utilization, and high cost-chronic diseases
- Promoting health care in accordance with local, state and national standards;
- Processing authorization requests timely and with adherence to all regulatory and accreditation timeliness standards

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

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

This Molina Provider Manual contains excerpts from Molina's Healthcare Services Program Description. For a complete copy of your state's Healthcare Services Program Description you can access the Molina website or contact the UM Department to receive a written copy. You can always find more information about Molina's UM program, including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer on Molina's website or by calling the UM Department.

Medical Groups/IPAs and delegated entities who assume responsibility for UM must adhere to Molina's UM Policies. Their programs, policies and supporting documentation are reviewed by Molina at least annually.

UM Decisions

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

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

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

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

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

Providers can contact Molina's Healthcare Services department at (844) 557-8434- to obtain Molina's UM Criteria.

Medical Necessity

"**Medically Necessary**" or "**Medical Necessity**"

- For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code

Per Welfare & Institutions Code Section 14133.3 (as amended by SB 1287), providers should provide fully documented medical justification that requested services are medically necessary or a medical necessity, as defined in Section 14059.5, on all requests for prior authorization.

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

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

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

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Medical Necessity Review

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

Levels of Administrative and Clinical Review

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

- Verifying Member eligibility
- Requested service is a covered benefit

- Requested service is within the Provider's scope of practice
- The requested covered service is directed to the most appropriate contracted specialist, facility or vendor

The Clinical review includes medical necessity and level of care.

- Requested service is not experimental or investigation in nature
- Servicing Provider can provide the service in a timely manner
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition
- Medical necessity criteria (according to accepted, nationally recognized resources) is met
- The service is provided at the appropriate level of care in the appropriate facility; e.g., outpatient versus inpatient or at appropriate level of inpatient care
- Continuity and coordination of care is maintained
- The PCP is kept appraised of service requests and of the service provided to the Member by other Providers

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

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

Clinical Information

Molina requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations allows such documentation to be acceptable.

Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at www.MolinaHealthcare.com.

Providers are encouraged to use the Molina prior authorization form provided on the Molina web site. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number)
- Provider demographic information (referring Provider and referred to Provider/facility)
- Member diagnosis and ICD-10 codes
- Requested service/procedure, including all appropriate CPT and HCPCS codes
- Location where service will be performed
- Clinical information sufficient to document the medical necessity of the requested service is required including:
    - Pertinent medical history (include treatment, diagnostic tests, examination data)
    - Requested length of stay (for inpatient requests)

- Rationale for expedited processing

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon medical necessity and member eligibility at the time of service.

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the member's clinical situation. The definition of expedited/urgent is when the situation where the standard time frame or decision-making process could seriously jeopardize the life or health of the enrollee or could jeopardize the enrollee's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited request for authorization, a determination is made as promptly as the member's health requires and no later than seventy-two (72) hours after we receive the initial request for service in the event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a member's life or health. For a standard authorization request, Molina makes the determination and provides notification within five (5) business days.

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (844) 557-8434.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider by telephone if at all possible or by fax with confirmation of receipt if telephonic communication fails.

Requesting Prior Authorization

Provider Portal: Participating Providers are encouraged to use the Molina Provider Portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are

available on the Molina Provider Portal. The benefits of submitting your prior authorization request through the Provider Portal are:

- Create and submit Prior Authorization Requests
- Check status of Authorization Requests
- Receive notification of change in status of Authorization Requests
- Attach medical documentation required for timely medical review and decision making

Fax: The Prior Authorization Request Form can be faxed to Molina at: (800) 811-4804.

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services Department at (844) 557-8434. It may be necessary to submit additional documentation before the authorization can be processed.

Mail: Prior authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:
Molina Healthcare of California

Attn: Healthcare Services Dept.
200 Oceangate, Suite 100
Long Beach, CA 90802

Molina has contracted with eviCore Healthcare (eviCore) to manage preauthorization requests for the following specialized clinical services:

- Imaging and Special Test
  - Advanced Imaging (MRI, CT, PET, Selected Ultrasounds)
  - Cardiac Imaging
- Radiation Therapy
- Sleep Covered Services and Related Equipment
- Genetic Counseling and Testing

Please refer to the Molina Prior Authorization Code Matrix located on the www.MolinaHealthcare.com website and contact eviCore visit website: www.evicore.com and/or call phone number: (888) 333-8144

(844) 557-84348:30 a.m. to 5:30 p.m.

Emergency Services

Emergency Services means: Those services needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition or Emergency means: a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part

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

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

Molina accomplishes this service by providing a twenty-four (24) hour Nurse Advise line for post business hours. In addition, the 911 information is given to all Members at the onset of any call to the plan.

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

Members over-utilizing the emergency department will be contacted by Molina Case Managers to provide assistance whenever possible and determine the reason for using Emergency Services.

Case Managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Emergency Department Support Unit

While the Member is in the Emergency Room, please fax all clinical records to the dedicated EDSU fax number: (877) Molina 5 or (877) 665-4625. This fax number is used exclusively for Members currently in the ER, to help expedite requests and assist with discharge planning.

Molina's Emergency Department Support Unit (EDSU) will collaborate with the ER to provide assistance to ensure Members receive the care they need, when they need it.

The EDSU is a dedicated team, available twenty-four (24) hours a day, seven (7) days a week to provide support by:

- Assisting in determining appropriate level of placement using established clinical guidelines.
- Issuing authorizations necessary, for admission, transportation, or home health
- Involving a Hospitalist or On-Call Medical Director for any Peer-to-Peer reviews needed
- Working with pharmacy to coordinate medications or infusions as needed
- Obtaining SNF placement if clinically indicated
- Coordinating placement into Case Management with Molina when appropriate
- Beginning the process of discharge planning and next day follow-up with a Primary Care Provider if indicated

For EDSU, Call: (844) 9-Molina or (844) 966-5462

Inpatient Management

Elective Inpatient Admissions

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

Emergent Inpatient Admissions

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

Inpatient at time of Termination of Coverage

If a Member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility are not covered services.

Inpatient/Concurrent Review

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

Molina will authorize hospital care as an inpatient, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge the Provider must provide Molina with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

Molina's UM staff follow CMS guidelines to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and medical necessity requirements (refer to the Medical Necessity Standards section of this manual).

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

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

Readmissions

Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.
Molina will conduct readmission reviews for participating hospitals when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates. If it is determined that the subsequent admission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

- A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
    - Premature or inadequate discharge from the same hospital;
    - Issues with transition or coordination of care from the initial admission;

- For an acute medical complication plausibly related to care that occurred during the initial admission.

- Readmissions that are excluded from consideration as preventable readmissions include:
  - Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns
  - Certain chronic conditions for which subsequent Readmissions are often either not preventable or are expected to require significant follow-up care
  - Neonatal and obstetrical Readmissions
  - Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed
  - Behavioral Health readmissions

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

Exceptions

1. The readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature or inadequate discharge, transition or coordination of care from the initial admission necessitated the second admission
2. The readmission is part of a medically necessary prior authorized or staged treatment plan.
3. There is clear medical record documentation that the patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning

Post Service Review

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

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

Affirmative Statement about Incentives

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

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

Open Communication about Treatment

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

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

Delegated Utilization Management Functions

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

Communication and Availability to Members and Providers

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling 844-557-8434during normal business hours, Monday through Friday (except for Holidays) from 8:30 a.m. to 5:30 p.m. All staff Members identify themselves by providing their first name, job title, and organization.

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

After business hours, Providers can also utilize fax and the Provider Portal for UM access.

Molina's Nurse Advice Line is available to Members and Providers twenty-four (24) hours a day, seven (7) days a week at (888) 275-8750. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters.

Out of Network Providers and Services

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

Those services needed to evaluate or stabilize an Emergency Medical Condition.

Coordination of Care and Services

Molina HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Molina's Integrated Care Management (ICM) program via assessment, self-

referral, provider referral, etc. It is the responsibility of contracted Providers to assess Members and with the participation of the Member and/or their authorized representative(s), create an individualized care plan (ICP). The ICP is documented in the medical record and is updated as conditions, needs and/or health status change. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

Molina staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

There are two (2) main coordination of care processes for Molina Members. The first occurs when a new Member enrolls in Molina and needs to transition current medical care to Molina contracted Providers. Mechanisms within the enrollment process identify the Members and the Member & Provider Contact Center (M&PCC) reach out to Members to assist in obtaining authorizations, transferring to contracted DME vendors, receiving approval for prescription medications, etc. The second coordination of care process occurs when a Molina Member's benefits will be ending, and they need assistance in transitioning to other care. The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

Continuity of Care and Transition of Members

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

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

For additional information regarding continuity of care and transition of Members, please contact Molina at 844-557-8434.

Reporting of Suspected Abuse and/or Neglect

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

or unable to protect him or herself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or childcare givers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers.

Suspected abuse and/or neglect should be reported as follows:

Child Abuse:

Link to Department of Social Services: https://www.cdss.ca.gov/reporting/report-abuse/child-protective-services/report-child-abuse
Imperial County: (760)-337-7750
Los Angele County:
(800)-540-4000 – Within CA
(213)-639-4500 – Outside CA
(800)-272-6699 – TDD
Online Reporting:
https://reportChildAbuseLA.org

Riverside County
(800)-442-4918
(877)-922-4453

Sacramento County
(916)-875-5437

San Bernardino County
(909)-384-9233
(800)-827-8724

San Diego County
(858)-560-2191
(800)-344-6000

Adult Abuse:

Imperial County
Adult Protective Services
Phone: (760) 337-7878
https://www.co.imperial.ca.us/districtattorney/elder-abuse.html

San Bernardino County
24-HOUR TOLL-FREE HOTLINE
1-877-565-2020
http://hss.sbcounty.gov/daas/programs/APS.aspx

San Diego County
Adult Protective Services
Phone: (800) 339-4661
Online submission: www. AISWebReferral.org
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/ais/adult_protective_services.html

Sacramento County
3701 Branch Center Road, Sacramento CA 95827
Phone: (916) 874-9377
Fax: (916) 854-9341
https://dcfas.saccounty.net/SAS/Pages/Adult-Protective-Services/SP-Adult-Protective-Services.aspx

Los Angeles County
24-Hour Abuse Hotline: (877) 477-3646

General Information, toll free in LA & Vicinity: (888) 202-4248

APS Mandated Reporter Hotline: (877) 477-3646 or (877) 4-R-Seniors - M-F, 8:30-5:00
https://wdacs.lacounty.gov/programs/aps/

Riverside County
DPSS – Adult Services Central Intake Center
4060 County Circle Drive
Riverside, CA 92503
Hotline: **1-800-491-7123**
Fax: **1**-951-358-3969
http://dpss.co.riverside.ca.us/adult-services-division/adult-protective-services

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

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

Those services needed to evaluate or stabilize an Emergency Medical Condition.

Continuity and Coordination of Provider Communication

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

Care Management

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

PCP Responsibilities in Care Management Referrals

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

Case Manager Responsibilities

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

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

Health Management

The tools and services described here are educational support for Molina Members. We may change them at any time as necessary to meet the needs of Molina Members.

Health Education/Disease Management

Molina offers programs to help our Members and their families manage a diagnosed health condition. You as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management

- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Obesity
- Weight Management
- Smoking Cessation

- Organ Transplant
- Serious and Persistent Mental Illness (SPMI) and Substance Use Disorder

Maternity Screening and High-Risk Obstetrics **Pregnancy Notification Process**

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at www.MolinaHealthcare.com) within one (1) working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Molina at (855) 556-1424.

For more info about our programs, please call: Provider Services Department at ((855) 322-4075 (TTY/TDD at 711 Relay).
Visit www.MolinaHealthcare.com

Member Newsletters

Member Newsletters are posted on the www.MolinaHealthcare.com website at least (two) 2 times a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials

Members are able to access our easy-to-read materials are about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, Members are directed to ask their doctor or visit our website.

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Molina Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the Member opts out. Identified Members will receive targeted outreach such as educational newsletters, telephonic outreach or other materials to access information on their condition. The program model provides an "opt-out" option for Members who contact Molina Member Services and request to be removed from the program.

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

- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim with a relevant CMS accepted diagnosis or procedure code;
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members;
- Provider referral;
- Nurse Advice referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication

Provider Participation

Contracted Providers are notified as appropriate, when their patients are enrolled in a health management program. Provider resources and services may include:

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

Additional information on health management programs is available from your local Molina HCS Department toll free at 844-557-8434.

Care Management (CM)

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

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

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

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

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing Emergency Department services inappropriately
- Children with Special Health Care Needs

Referrals to the ICM program may be made by contacting Molina at:
Phone: 800-526-8196 Ext: 127604

Fax: 562-499-6105

Specialty Pharmaceuticals/Injectables and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization. In some cases, they will be made available through a vendor, designated by Molina. More information about our Prior Authorization process is available in the Medical Management Program section of this Provider Manual.

Molina's pharmacy vendor will coordinate with Molina and ship the medication directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations Representative with any further questions about the program.

Newly FDA approved drugs are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee.

TRANSITIONS OF CARE (ToC) PROGRAM

Transitions of Care staff work collaboratively with both Members and providers to ensure the coordination and continuity of care from one care setting to another as the Member's health status changes. This is accomplished by providing Members with the tools and support that promote knowledge and self-management of their condition, and by facilitating improved Member and provider understanding of roles, expectations, schedules and goals. Such transitions occur, for example, when a Member moves from a home to a hospital as the result of an exacerbation of chronic conditions or moves from a hospital to a rehabilitation facility after surgery.

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

MHC's ToC program is delivered in one of two ways:

- *Transitions of Care Telephonic Coaching Program* is designed to reach a large volume of high-risk Members by making an inpatient hospital outreach call and three (3) or more subsequent phone calls within a four to six (6) week period of time from the date of the Member's initial admission.
- *Healthcare Transitions Program* is designed for Members to receive face-to-face contact with ToC staff – one in the hospital prior to discharge and/or one at home within two (2) business days of discharge targeted at members known to have admitting diagnoses which research has shown have the highest risk for readmission to an in-patient facility.

The aim of the ToC programs includes; preventing avoidable hospital readmissions, optimal transitioning from one care setting to another and/or identifying an unexpected change in condition requiring further assessment and intervention. Continuity of care post discharge communications may include, but not be limited to, phone calls and follow up letters to Members and their Primary Care Physicians (PCPs), specialty providers, other treating providers/practitioners as well as agencies providing long term services and supports (LTSS).
The MHC Transitions of Care Program focuses on four critical elements as the foundation to prepare members for successful transitions. Adapted from Dr. Eric Coleman's Model of Care Transitions Interventions (http://www.caretransitions.org) (Eric A. Coleman, MD, MPH) they include:

- Medication Management – MHC's transition staff will assist with the coordination of Member medication authorizations as appropriate; provide training to Members regarding their medications, and conduct medication reconciliation to avoid inadvertent medication discrepancies. Through its Pharmacy Benefit Manager (PBM), CVS Caremark, MHC will have up-to-date information readily available regarding the Member's current medications and medication history.
- Personal Health Record – MHC's ToC staff will assist with completion of a portable document with pertinent Member history, provider information, discharge checklist and medication record to ensure continuity across providers and settings.
- PCP and/or Specialist Appointments – MHC ToC staff re-establish the Member's connection to their medical home by ensuring that an appointment has been scheduled with the Member's Primary Care Physician (PCP) and/or appropriate specialist prior to discharge from a hospital. The goal is to arrange an appointment to occur within seven (7) days of discharge. ToC staff will facilitate appointment scheduling as well as transportation to ensure Members keep follow-up appointments.
- Knowledge of Red Flags – MHC's transitions staff will ensure Members are knowledgeable about and aware of indications that their condition is worsening and how to respond.

Transitions of Care staff function as a facilitator of interdisciplinary collaboration across the transition, engaging the Member, caregivers and providers to participate in the formation and implementation of an individualized care plan including interventions to mitigate the risk of re-hospitalization. The primary role of the transitions staff is to encourage self-management and direct communication between the Member and provider rather than to function as another health care provider.

Initial contact between the transitions staff and Member will be made during the inpatient stay. The MHC transitions staff will perform introductions, explain the program and describe the Member's role within the program. The Member may elect at this point not to participate in the program. The transitions staff will verify the provider, Member address and telephone number, and provide the Member with MHC care transitions information, including contact information to access their MHC representative. All Members also receive the toll-free Nurse Advice Line phone number to call if they have questions or concerns after hours and also a toll-free phone number to call when their assigned coach is not readily available to reach them. When calling this number, the Member will either be immediately assisted with their needs by another ToC Coach or if they choose, a message will be sent to their assigned ToC Coach to contact them. The toll-free phone number is 844-203-4287 and the hours of operation are 8:30 a.m. to 5:30 p.m., Monday through Friday.

The transitions staff will use a tool to assess the Member's risk of re-hospitalization and will assist in coordinating the discharge plan, which may include authorizing home care services or assisting the Member with after-treatment and therapy services.

The transitions staff also receives training in community resource referrals and will assist the Member when needed with referrals for items such as food, transportation and long-term services and supports. The ToC Program fits within MHC's Integrated Care Management Model, which promotes whole-person care. As the transitions program nears completion, if it is determined the Member has ongoing needs, the ToC coach will refer the Member to the Case Management and/or the PCP so that the member can receive further assessment and interventions to address those needs going forward.

8.1 HEALTHCARE SERVICES: CASE MANAGEMENT & LONG-TERM SERVICES AND SUPPORTS (LTSS)

The Molina Case Management (CM) Program is an integral part of the comprehensive Medical Management Program. The goal of case management is to improve the health and well-being of members, particularly those members with serious, debilitating or complex medical conditions by educating, assisting, and facilitating access to the most appropriate health care services available so that they may regain optimum health or improved functional capability, in the right settings and in a cost-effective manner. Case management involves assessment of the member's condition; determination of available benefits and resources; collaboration between Molina and providers and the development and implementation of an individualized, multidisciplinary case management plan with performance goals, monitoring and follow-up. It is the responsibility of contracted providers to assess members and with the participation of the member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

MHC's practitioners/providers are an integral part of the Case Management Program. The state of California requires that Primary Care Providers and Molina provide Comprehensive Medical Case Management to each member. These services are provided by the Primary Care Provider (PCP) in collaboration with Molina to ensure the coordination of medically necessary health care services including waiver program or carved out services, the provision of preventive services in accordance with established standards and periodicity schedules, and continuity of care for members. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs. The extent of collaboration with the plan is based on the needs identified by the PCP which could include but is not limited to coordination with Care Access & Monitoring staff for authorizations, Secure Transportation for non-medical transportation services, Pharmacy staff regarding the Molina Formulary or Case Management staff for additional support in care coordination.

The Molina case managers are professionals and are educated, trained and experienced in the case management process. The CM program is based on a member advocacy philosophy, designed and administered to assure the member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. Molina staff assists providers by identifying needs and issues that may not be verbalized by providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with providers and members to ensure efforts are efficient and non-duplicative.

Based on the needs of the member, Comprehensive Medical Case Management services are described as either Basic or Complex:

- **Basic Case Management** services are provided by the primary care provider in collaboration with the Plan and include:
  - Initial Health Assessment (IHA)
  - Initial Health Education Behavioral Assessment (IHEBA)
  - Identification of appropriate providers and facilities to meet member care needs (such as medical, rehabilitation, and support services)
  - Direct communication between the provider and member/family
  - Member and family education, including healthy lifestyle changes when warranted

- Coordination of carved out and linked services, and referral to appropriate community resources and other agencies, including but not limited to California Children's Services (CCS), Regional Centers, In Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), etc.
- Complex Case Management services are provided by the primary care provider, in collaboration with the Plan, and include:
- Basic Case Management Services (described above)
- Management of acute or chronic illness, including emotional and social support issued by a multidisciplinary case management team
- Intense coordination of resources to ensure member regains optimal health or improved functionality
- With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually
- Services for Seniors and Persons with Disabilities (SPD) beneficiaries must include the concepts of Person-Centered Planning

Identifying Members for Case Management

All Members receive Basic Case Management services from the PCP with varying collaboration from the Plan based on the Member's needs. For members who need greater involvement from Plan case management staff (such as Members with Medicare and Medi-Cal and Seniors & Persons with Disabilities), Molina proactively identifies members who need Case Management from MHC using a variety of clinical care processes and data sources including but not limited to utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical and administrative data (claims data, encounter data, hospital admission/discharge data, pharmacy data obtained from Pharmacy Benefit Management (PBM) organization and/or State, data collected through the Care Access and Monitoring (CAM) process (including prior authorization data, concurrent review data), laboratory results, reinsurance reports, frequent emergency department (ED) use reports and/or predictive modeling software programs/reports), and any other available data. In addition, MHC's case management software platform system contains a rules engine that identifies and stratifies members that are appropriate candidates for CM through system-based rules that consider certain medical conditions, utilization, claims, pharmacy, and laboratory data.

In addition, Molina provides multiple avenues for members to be referred to the Plan for case management services beyond what the PCP provides, including telephone, fax or email:

FAX: (562) 499-6105 PHONE: (800) 526-8196 ext. 127604
MHCCaseManagement@MolinaHealthcare.com

Molina welcomes referrals from PCPs, hospital discharge planners, social workers, CCS case managers, Early Start staff, members and/or member's family/caregiver, specialty physician, and other practitioners. CM Program and contact information is also available from Member Services, 24-hour Nurse Advice Line and in the Health Care Professionals sections on the Molina website.

Members appropriate for Complex Case Management are those who have complex service needs and may include your patients with multiple medical conditions, high level of dependence, conditions that require care from multiple specialties and/or have additional social, psychosocial, psychological and emotional issues that exacerbate the condition, treatment regime and/or discharge plan.

PCP Responsibilities in Case Management Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with reports, updates, and information regarding

the member's progress through the case management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Case Manager Responsibilities

The Molina case manager collaborates with all resources involved and the Member to develop a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the case manager, providers, and the member are responsible for implementing the plan of care. Additionally, the case manager:

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

Assessment and Leveling

Members who have been identified for CM by MHC are assigned to the appropriate Molina staff. New cases are prioritized and managed according to urgency. The staff reviews all available information (such as the source and reason for referral, utilization data, etc.) and contacts the member by telephone to perform an assessment. Members have the right to decline participation or to disenroll from the CM program at any time. Molina Members are assumed to be in the program unless they opt out. However, members cannot opt out of the Basic Case Management provided by their PCP.

The assigned CM makes three attempts to reach the member by phone on different days and times. If the member cannot be reached, the CM will attempt to find other phone numbers (e.g. from PCP office, pharmacy, hospital face sheets, etc.). If no other phone numbers are found or those other numbers yield no contact, the CM sends an "unable to contact" letter. If appropriate, the CM may also refer the member to a Community Connector who will attempt to locate the member at the physical and mailing addresses on file in Molina's membership database. If the mail is not returned to Molina, the member does not contact Molina within fourteen (14) calendar days, and/or the Community Connector does not locate the member it will be assumed that the member does not desire CM.

During the first contact with the member by Molina staff, an initial assessment is completed or an appointment for completing the assessment is made. The initial assessment will be initiated as expeditiously as the member's condition requires and will be completed within thirty (30) days of assignment. The assessment may be completed in multiple contacts. The assessment is conducted either telephonically, or during a home visit. Home visits are considered an enhancement to accurate assessment and will be made to provide a more accurate evaluation of the member and their circumstances and needs when deemed appropriate. Molina's CM process includes an assessment of the member's health status, including an evaluation of their medical, psychosocial and behavioral health situation and needs as well as condition-specific issues. The assessment provides the Molina case manager with the foundational information that is used to develop an individualized plan of care.

These assessments include the following elements based on NCQA, State and Federal guidelines:

- Health status and diagnoses
- Clinical history
- Medications prescribed
- Activities of daily living, functional status, need for or use of LTSS

- Cultural and linguistic needs
- Visual and hearing needs
- Caregiver resources
- Available benefits and community resources, including carved out and linked services such as behavioral health, substance abuse, long term supportive services, California Children's Services, Early Start, etc.
- Life-planning activities (e.g., healthcare power of attorney, advance directives)
- Body Mass Index
- Smoking
- Confidence
- Readiness to change
- Member's desire / interest in self-directing their care
- Communication barriers with providers
- Treatment and medication adherence
- Emergency Department and inpatient use
- Primary Care Physician visits
- Living situation
- Psychosocial needs (e.g., food, clothing, employment)
- Durable medical equipment needs
- Health goals
- Mental health and
- Chemical dependency

Based on the on the member's responses to the initial health risk assessment, additional condition-specific health assessments may be used to determine what level/intensity of case management is needed. The case manager then works with the member to identify interventions that support member achievement of short- and long-term goals. For all levels, the focus of the interventions is to provide member education and/or to coordinate access to services which will lead to the most appropriate levels of care and utilization of health services while maintaining or improving the members' health and functioning.

Basic Case Management				
Case Management			Complex Case Management	
PCP + Molina Care Coordination	Level 1 Health Management	Level 2 Care Interventions	Level 3 Complex	Level 4 Intensive Need

Once a determination has been made that the member will participate in case management, the Care Manager sends the member a welcome letter. A copy of the welcome letter is also sent to the member's primary care physician and any applicable specialty physicians.

The resulting care plan is approved by the member, may be reviewed by the Interdisciplinary Care Team (ICT) and maintained and updated by the Case Manager as the member's condition changes. The Case Manager also addresses barriers with the member and/or caregiver and collaborates with providers to ensure the member is receiving the right care, in the right setting, with the right provider.

The purpose of the HCS program interventions at all levels is to ensure that the member and/or family understands and agrees with the care plan, understands the member/family/physician/case manager role in fulfilling the care plan, key self-management concepts and has the resources for implementation. All member education is consistent with nationally accepted guidelines for the particular health condition.

Level 1 – Health Management

Health Management is focused on disease prevention and health promotion. It is provided for members whose lower acuity chronic conditions; behavior (e.g., smoking or missing preventive services) or unmet needs (e.g., transportation assistance or home services) put them at increased risk for future health problems and compromise independent living. The goal is to achieve member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation throughout the continuum of care.

At this level, Members receive educational materials via mail about how to improve lifestyle factors that increase the risk of disease onset or exacerbation. Topics covered include smoking cessation, weight loss, nutrition, exercise, hypertension, hyperlipidemia, and cancer screenings, among others. Members are given the option, if they so choose, to engage in telephone-based health coaching with Health Management staff, which includes nurses, social workers, dieticians, and health educators.

Level 2 – Case Management

Case Management is provided for Members who have medium-risk chronic illness requiring ongoing intervention. These services are designed to improve the Member's health status and reduce the burden of disease through education and assistance with the coordination of care including LTSS. The goal of Case Management is to collaboratively assess the Member's unique health needs, create individualized care plans (ICPs) with prioritized goals, and facilitate services that minimize barriers to care for optimal health outcomes. Case Managers have direct telephonic access with Members. In addition to the member, Case Management teams also include pharmacists, social workers and behavioral health professionals who are consulted regarding patient care plans. In addition to telephonic outreach to the member, the Case Manager may enlist the help of a Community Health Worker or Community Connector to meet with the Member in the community for education, access or information exchange.

Level 3 – Complex Case Management

Complex Case Management is provided for Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the health care system to facilitate the appropriate delivery of care and services.

The goal of Complex Case Management is to help Members improve functional capacity and regain optimum health in an efficient and cost-effective manner. Comprehensive assessments of Member conditions include the development of a case management plan with performance goals and identification of available benefits and resources. Case Managers monitor, follow-up and evaluate the effectiveness of the services provided on an ongoing basis. Complex Case Management employs both telephonic and face-to-face interventions.

MHC continues to look for innovative ideas to promote health, for instance, MHC has implemented a Community Connector program for members receiving Level 2-4 Case Management. Community Connectors use a Community Health Worker model in order to support MHC's most vulnerable members within their home and community with social services access and coordination. They serve as patient navigators and promote health within their own communities by providing education, advocacy and social support.

Level 4 – Intensive Needs

Level 4 focuses on Members with intensive needs who are at risk of an emergency department visit, an inpatient admission, or institutionalization, and offers additional high intensity, highly specialized services. These members often have been high utilizers of medical services. Members who may be candidates for organ transplant or who may be considered for other high-risk or specialized treatments (e.g. LVAD) are also placed into this level. Level 4 also includes those Members who are currently institutionalized but qualify to transfer to a home or community setting. Populations most often served in Level 4 are the Dual-Eligible (Medicare/Medicaid), those with severe and persistent mental illness (SPMI), those with Dementia, and the Developmentally Delayed. These services are designed to improve Member's health status and reduce the burden of disease through education as described in Level 1.

These criteria include meeting an intensive skilled nursing (ISN) level of care, facing an imminent loss of current living arrangement, deterioration of mental or physical condition, having fragile or insufficient informal caregiver arrangements, having a terminal illness, and having multiple other high-risk factors.

Comprehensive assessments of Level 4 conditions include: assessing Member's unique health needs utilizing the comprehensive assessment tools; identifying potential facility transitions and needs for LTSS referral coordination; participating in Interdisciplinary Care Team (ICT) meetings; creating individualized care plans (ICPs) with prioritized goals; and facilitating services that minimize barriers to care for optimal health outcomes.

If the Member's Level requires case management at a higher or lower level than the staff assigned can provide or the Member's needs require assignment to a staff person with particular subject matter expertise, the staff will discuss the findings with his/her supervisor so that the Member can be assigned accordingly. For example, if a Member is assessed by a case manager who is a RN with expertise in clinically complex conditions and the Member's needs are assessed to be primarily related to a behavioral health condition, the Supervisor would reassign the case to a case manager of an appropriate discipline with experience in behavioral health. Similarly, should a case manager with a Master's in Social Work assess a member with severe heart disease who is a candidate for transplant, the Supervisor would identify a case manager with the appropriate discipline and experience.

Case Management Process / Development of a Plan of Care

The Member's PCP is the primary leader of the health team involved in the coordination and direction of care services for the Member. If the Member is receiving case management services from the PCP only, the plan of care is documented in the Member's medical record. If the Member is also receiving case management services from Molina staff, the care plan is created within thirty (30) days of completing the assessment. The care plan is maintained in Molina's case management software platform "Clinical Care Advance (CCA)" and a copy is sent to the PCP for review and inclusion in the medical record.

An individualized plan of care is required for each Member using Person-Centered planning and treatment approaches that are collaborative and responsive to the Member's health care needs. Members can choose to include any family, friends and professionals to participate in discussions or decisions regarding treatments, services or other elements of the care plan. Specific activities and interventions tailored to the needs of the individual must be included, assuring consideration for the Member's or responsible party's goals, preferences and choices.

Care plans created by Molina staff in the CCA System contain Guidelines and Milestones that are used to identify member needs, actions related to those needs, desired outcomes and evaluation criteria. Guidelines in CCA are defined as a standard set of Goals and Milestones that reflect the best practices for a particular

problem or diagnosis. Documentation from the Member assessment as well as a variety of other sources such as physician offices, facility medical records and discharge planners in other organizations etc. will be considered in the process of case management assessment and planning. Based on Member needs and preferences the case management staff will solicit input from a multidisciplinary team such as the Member's PCP, specialist physician, home health provider, CCS or Regional Center liaison, and Molina subject-matter experts such as pharmacist, dietitian, social worker or Medical Director.

Molina case management staff will:

- Ensure members receive all necessary information regarding treatment or services so that they may make informed choices
- Follow the appropriate process for services requiring authorization with clinical review
- Discuss the care plan and/or follow up activities with the member
- Create care plans that include:
  - Problems – a minimum of one problem, three for complex members
  - Goals – An established target that a member should meet within a guideline/care plan. Short Term Goal = sixty (60) days or less - Long Term Goal > sixty (60) days. Complex cases contain at least one short-term goal and one long-term goal and the goals must be prioritized and measurable. Progress towards goals is assessed at least quarterly
  - Interventions - Interventions provide the implementation of content developed to aid patients or practitioners; they may include phone calls, e-mails, mailings, coaching, home visits, advice, reminders, tools and biometric devices. Plans for continuity of care including transition of care and transfers are included and approaches to collaboration with family members, other Care Managers such as those from home health, hospice, acute or long-term care, physicians, waiver programs, state case workers etc. are included as appropriate
  - Outcome - The anticipated result of a planned intervention within a guideline in the care plan
  - Barriers – Barriers to care will be addressed including those relative to the Member's ability to achieve goals or to comply with their treatment plan. Such things as the Member's lack of understanding, ability to understand, motivation, financial need, insurance issues, transportation problems, lack of family or other caregiver support, inadequate or inappropriate housing, social and cultural issues / isolation, and so forth may be considered
  - Resources to be utilized, including level of care - Also included in the plan will be resources to be utilized such as the Complex Care Manager, Medical Care Manager, Social Worker, Disease Care Manager, Disease Management Program, education, cultural and linguistic services, etc. Plans for continuity of care including transition of care and transfers will also be included. Approaches to collaboration with family members, other Care Manager(s) such as those from home health, hospice, acute or long-term care, physicians, waiver programs, state case workers, etc. will be included as appropriate
  - Time frames/schedules for reevaluation - will be determined and documented in the case management plan. Member progress toward goals and overcoming barriers will be assessed and documented as frequently as needed and no less than quarterly. Plan goal adjustments will be made based on the unique and changing needs of the member and will consider such things as the Member's overcoming barriers to care and meeting their treatment goals. Ongoing assessment-reassessment, goal adjustment, and modification of the care plan are considered core case management activities and will be completed and documented in a timely manner. Such changes will be communicated to the member and / or caregiver and other collaborators
  - Planning for continuity of care, including transition of care and transfers
  - Collaborative approaches to be used, including family participation
  - A schedule for follow-up and communication with the Member is documented within the care plan

- Member Self-Management Plan – The case manager will develop, document, and communicate a plan for Member self-management that may include such things as members' monitoring and daily charting of their symptoms, activities, weight, blood pressure, glucose levels, daily activity, and their compliance with dietary and/or fluid intake, dressing changes and other prescribed therapies. Focus will be on activities that are designed to shift the focus in patient care from members receiving care from a practitioner or care team to members providing care for themselves, where appropriate

The PCP will be invited and must be an active participant in the Member's Interdisciplinary Case Team (ICT). Each CM is responsible for sending the care plan to the member and their assigned PCP. We request that the PCP review every care plan and provide additional observations and information as appropriate to support the member's care coordination preferences and needs. All care plans whether they are authored by Molina staff and/or PCPs be clearly documented in the Member's medical records.

Health Education and Disease Management Programs

Molina's Health Education and Disease Management programs will be incorporated into the member's treatment plan to address the Member's health care needs. Primary prevention programs may include smoking cessation and wellness.

Referrals to State or County Case Management Programs

When a Member is identified as being eligible for a County or State supported health care program, a MHC Case Manager may assist the PCP to ensure timely referral to the appropriate program. The PCP, with the patient's/family's approval, makes the referral to the program. The PCP will coordinate primary medical care services for Members who are eligible.

Case Management Process / Reassessment

The case management plan includes a schedule for reassessment of member progress towards overcoming barriers to care and goal achievement. Reassessment schedules depend on the complexity and/or stability of Member's situation. For example, if the Member has transitioned from one level of care to another or has experienced a significant medical (e.g. stroke) or life event (e.g. eviction leading to homelessness) that could impact their ability to manage their health. A schedule for follow-up, communication with the Member and reassessment is established by the case manager. Reassessment will include the Chronic Disease Self-Management Program Assessment every ninety (90) days for members in Levels 2-4.

Regular meetings (case rounds) with appropriate plan leadership and Medical Director will occur as needed to evaluate the feasibility of treatment plan and progress toward goals. The Member's case will also be assessed for transitional needs into or out of Complex Case Management services: at the request of the PCP or Member; upon achievement of targeted outcomes; and/or upon change of health care setting.

Case Closure

The Member will remain in Case Management until one of the following occurs: Member has terminated/transferred membership from Molina; Member has expired; or Member refuses or withdraws consent for case management. In addition, if the Care Manager is unable to contact Member for updates and/or reassessment. If the Member achieves their targeted outcomes or otherwise does not meet the criteria for Level

1, the Molina staff will perform a Chronic Disease Self-Management Program Assessment survey and a Case Closure letter will be sent. The PCP and Member will be notified that the Member can re-engage with Molina case management staff if their condition changes and case management by health plan staff is needed again.

Outcomes Evaluation/Measuring Effectiveness

MHC uses a variety of approaches to evaluate the effectiveness of the program. Member satisfaction with the MHC Case Management Program is measured at least annually via a survey of Members whose case management cases were closed or whose case is currently open to case management and have received services for a minimum of sixty (60) days. The survey measures the overall program and the usefulness of case management services. Areas of survey measurement include Member's adherence to treatment plan, knowledge of condition, and appropriate service coordination. Member satisfaction is also measured via an analysis of member complaints related to the program. Clinical measures include Health Employer Data and Information Set (HEDIS) effectiveness of care measures and National Quality Forum measures for chronic illness. Health status and mental health status are measured based upon a comparison of SF-12® measures over time. Utilization data such as admissions, ED visits and bed days and readmission rates per thousand per year are also analyzed. Process measures also look at average cases per case manager, referral sources and reasons, decline rates, etc.

8.2 HEALTHCARE SERVICES: WOMEN'S & ADULT HEALTH SERVICES, INCLUDING PREVENTIVE CARE

PREGNANCY AND MATERNITY CARE

All pregnant and postpartum women must be offered access to the Comprehensive Perinatal Services Program (CPSP) or equivalent services. This includes the multi-disciplinary integration of health education, nutrition, and psychosocial assessments. In addition, pregnant and postpartum women have access to medical/obstetrical care, genetic counseling, case coordination/case management, individualized care plan (ICP) development with updates, trimester reassessments, and postpartum assessment to include health education, nutrition and psychosocial assessments, and medical/obstetrical care to both the common and identified high-risk pregnancy/postpartum member within sixty (60) days postpartum.

Provider/Practitioner Responsibilities

OB care Providers/Practitioners are strongly encouraged to be CPSP certified or have a formal relationship with a CPSP certified Provider/Practitioner for the provision of CPSP support services. All pregnant members shall be referred and assigned to CPSP certified Providers/Practitioners for CPSP services, whenever possible. The CPSP Providers/Practitioners shall be involved with the following:

- Integration of clinical health education, nutrition, and psychosocial assessment
- Medical obstetrical care, genetic counseling, and case coordination/management
- Use of appropriate documentation and care planning tools
- Submission of encounter and outcomes data

As of July 1, 2019 AB, 2193 Maternal Mental Health requires a licensed health care practitioner who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. A health provider must use a validated tool to assess the member's mental health, either in the prenatal or postpartum period, or both. Two examples are the Patient Health Questionnaire-9 (PHQ-9) and the Edinburgh Postnatal Depression Scale (EPDS). Molina requires healthcare providers to document mental health screening for pregnant or postpartum members using the current CPT/HCPCS claim codes. Molina Maternal Mental Health Program guidelines and criteria are available upon request by contacting the Provider Contact Center.

CPSP Certified Providers/Practitioners of Perinatal Services

- CPSP Certified Providers/Practitioners shall be responsible for providing and complying with all CPSP service requirements for their pregnant and postpartum members up to sixty (60) days after delivery
- CPSP Certified Providers/Practitioners shall be responsible for complying with MHC's policy and procedure and Comprehensive Perinatal Services Program (CPSP) requirements and standards including use of appropriate assessment, documentation, and care planning tools; submission of reporting forms (i.e. Pregnancy Notification Report)
- All CPSP Providers/Practitioners will receive information on how to obtain copies of CPSP's "Steps to Take" materials which provide helpful information to staff members to effectively assess, provide intervention for common pregnancy related conditions/ discomforts and how to appropriately refer pregnant members to all appropriate services

Non-CPSP Certified Providers/Practitioners of Perinatal Services

Non-CPSP Providers/Practitioners **must** comply with MHC policy and procedures and standards including:

- Use of appropriate assessment, documentation, and care planning tools
- Submission of reporting forms (e.g., Pregnancy Notification Report)
- Employment of appropriate, qualified staff (e.g., CPHW)

MHC's Perinatal Services Staff may also perform audits/reviews on, but not limited to, the following:

- Member satisfaction questionnaire
- Member complaints

MHC and the Local Health Departments shall provide a consolidated effort to promote, encourage, and assist all Non-CPSP Providers/Practitioners in obtaining CPSP certification through the Department of Health Care Services. MHC and the Local Health Department shall provide ongoing support to all MHC contracted CPSP certified Providers/Practitioners.

Non-CPSP certified Providers/Practitioners may choose to outsource CPSP services. MHC Perinatal Services Staff shall provide technical assistance to Non-CPSP Providers/Practitioners in referring members to appropriate facilities (clinics, hospitals, etc.) as necessary. Non-CPSP certified Providers/Practitioners may refer their high-risk pregnancies to MHC's Motherhood Matters Program.

For more information on how to become a DHCS certified CPSP Provider/Practitioner, call the appropriate CPSP Program Coordinator:

- Imperial (760) 482-2905
- Los Angeles (213) 639-6427
- Riverside (951) 358-5260
- Sacramento (916) 875-6171
- San Bernardino (909) 388-5751
- San Diego (619) 542-4053

Authorization

Prior authorization or approval certification for either the OB or CPSP services provided for pregnant or postpartum members [defined as up to sixty (60) days after delivery] is not required.
Members may see any qualified contracted Provider/Practitioner, including their PCP, an obstetrician/gynecologist, or a nurse midwife for prenatal care. Note: members in capitated IPA/Medical Groups must obtain an obstetrical Provider/Practitioner within their IPA/Medical Group network.

Member Participation

Prior to the administration of any assessment, drug, procedure, or treatment, the member must be informed of the following:

- Potential risks or hazards which may adversely affect her or her unborn infant during pregnancy, labor, birth, or postpartum
- Alternative therapies available to her
- The member has a right to consent to or refuse the administration of any assessment, drug,
- Procedure, test, or treatment. The refusal of any MHC member to participate in CPSP must be documented in the member's medical record by the Provider/Practitioner or Perinatal Support Staff offering the CPSP service. Member participation is strongly encouraged, but is voluntary

Perinatal Support Staff as defined in this document includes:

- Certified Nurse Midwives
- Registered Nurse Practitioners (Family and/or Pediatric)
- Physician Assistants
- Registered Nurses
- Social Workers
- Psychologist
- Dietitians
- Health Educators
- Child Birth Educators
- Comprehensive Perinatal Health Workers (CPHW)
- Medical Groups
- Medical Clinics
- Hospitals
- Birthing Centers
- Case Manager

PREVENTIVE CARE

MHC requires contracted Providers/Practitioners of Perinatal Services to adhere at minimum to the current American College of Obstetrics and Gynecologists (ACOG) Standards, current edition.

MHC Prenatal Preventive Care Guidelines (PHGs) are derived from recommendations from nationally recognized organizations, such as the ACOG, U.S. Preventive Services Task Force, the American Academy of Family Physicians, and others. They are updated annually. The Prenatal PHG is available on the MHC webpage at www.MolinaHealthcare.com.

Perinatal Services Available to Members and Providers/Practitioners

The MHC UM Department shall be responsible for reviewing all referrals and treatment authorization requests for Perinatal Services of MHC members where prior authorization is required. Please refer to MHC's Prior Authorization Guide in the Healthcare Service Section.

Frequency Scheduling of Perinatal Visits/Re-Assessments

MHC Providers/Practitioners shall follow ACOG's Guidelines for Perinatal Care regarding the frequency of visits/reassessments: Uncomplicated Pregnancy

- Every four (4) weeks for the first twenty-eight (28) weeks.
- Every two (2) to three (3) weeks until the thirty-sixth (36th) week.
- After the thirty-sixth (36th) week, then weekly until delivery.
- Postpartum, three (3) to eight (8) weeks after delivery.

Complicated/High-risk Pregnancy

- Frequency as determined by the member's Provider/Practitioner or Perinatal Support Staff according to the nature and severity of the pregnant member identified risk(s).
- Women with medical or obstetrical risks may require closer surveillance than the ACOG recommendations.

Biochemical Lab Studies

The Perinatal Support Staff shall ensure the following biochemical lab studies are completed as part of the member's initial risk assessment:

- Urinalysis, including microscopic examination and infection screen
- Hemoglobin/Hematocrit
- Complete Blood Count
- Blood Group, ABO and RH type
- Antibody screen
- Rubella antibody titer
- Syphilis screen (VDRL/RPR)
- Gonorrhea culture
- Chlamydia culture
- Urinary Ketones
- Serum Albumin
- Hepatitis B virus screen
- Cervical Cytology
- Tuberculosis testing
- Hemoglobin electrophoresis
- Blood volume
- One-hour glucose screen
- Screening for Genetic Disorders

The Perinatal Support Staff shall ensure all pregnant Members who have a history of one (1) or more of the following shall have genetic disorder screening performed as part of the Member's initial risk assessment and are referred to a genetic counseling center or genetic specialist, as appropriate:

- Advanced maternal age (thirty-five [35] years of age or older)
- Previous offspring with chromosomal aberration
- Chromosomal abnormality in either parent
- Family history of a sex-linked condition
- Inborn errors of metabolism
- Neural tube defects
- Hemoglobinopathies
- Ancestry indicating risk for Tay-Sachs, Phenylketonia (PKU), Alpha or Beta Thalassemia, Sickle Cell Anemia, and Galactosemia

The Perinatal Support Staff must initiate appropriate interventions in response to any problems, needs, or risks identified during the initial combined risk assessment and document in the Member's Individualized Care Plan. Upon the Provider/Practitioner's recommendations and Member consent, the appropriate procedure(s) shall be performed (i.e., amniocentesis). The Provider/Practitioner shall give results of procedure(s) to the Member. Appropriate follow-up intervention shall occur, as necessary

INITIAL COMBINED PRENATAL RISK ASSESSMENT/REASSESSMENT OF THE PREGNANT MEMBER OVERVIEW

The Initial Combined Prenatal Risk Assessment/Re-Assessment is a combined risk assessment which includes medical/obstetrical, psychosocial, nutritional, and health educational components.

Perinatal Support Staff Responsibilities

Perinatal Support Staff shall be responsible for assessing and evaluating the following:

- Member's Prenatal Assessment Profile
- Women's Food Frequency Questionnaire
- Prenatal Weight Gain Grid - Nutritional Assessment
- Psychosocial and Health Education assessment of the pregnant Member
- Individualized Care Plan, as appropriate, utilizing the following initial prenatal assessment tools
- Perinatal Support Staff shall report all relevant information obtained during their assessments/reassessments to the Provider/Practitioner and document in the Member's record
- Prenatal Assessment Profile shall be available in threshold language for the specific geographic areas of membership
- Perinatal Support Staff shall be available to assist member in completion of Prenatal Assessment Profile if member is unable to complete independently
- Perinatal Support Staff signature shall be required if assistance was provided to Member for completion of Prenatal Assessment Profile
- Perinatal Support Staff shall review Member's response to the Prenatal Assessment Profile, identify, and discuss any responses that could indicate a potential risk
- Perinatal Support Staff shall assign a risk status of "High, Medium, or Low" for each answer on the Prenatal Assessment Profile as determined by the Member's response
- Perinatal Support Staff must initiate appropriate interventions in response to the Member's identified and assigned risk status from the Prenatal Assessment Profile

NUTRITIONAL ASSESSMENT/REASSESSMENT – WOMEN'S FOOD FREQUENCY QUESTIONNAIRE

- Re-caps the Member's food intake for the prior twenty-four (24) hours to determine pregnant Member's current nutritional status
- Women's Food Frequency Questionnaire shall be available in threshold languages for the specific geographic areas of membership. Perinatal Support Staff shall be available to assist Member in completion of Women's Food Frequency Questionnaire if Member is unable to complete independently
- Perinatal Support Staff shall review Member's response to the Women's Food Frequency Questionnaire and discuss any responses that could indicate a barrier to adequate nutritional intake (i.e. alcohol/tobacco or drug use; infant feeding problems; or socioeconomic factors potentially affecting dietary intake). Member will be evaluated for the WIC Program, Food Stamps, etc. Member must be referred to the WIC Program within four (4) weeks of the first prenatal visit. The Perinatal Support Staff shall initiate appropriate interventions in response to the Member's identified nutritional risk status. The Perinatal Support Staff shall utilize relevant information obtained from the Women's Food Frequency Questionnaire to assist in the development of the member's Individualized Care Plan

ANTHROPOMETIC ASSESSMENT - PRENATAL WEIGHT GAIN GRID

- The Perinatal Support Staff shall obtain the Member's weight (in pounds) at the initial prenatal assessment and plot on the DHCS-approved Prenatal Weight Gain Grid
- The Perinatal Support Staff shall obtain a new weight at each perinatal assessment and plot accordingly on the Prenatal Weight Gain Grid. The Perinatal Support Staff shall compare the current weight and the total amount gained with the gain expected for the Member. The Perinatal Support Staff shall consider the results of weight assessment and results of the dietary and clinical assessments to determine appropriate nutritional

interventions
- The Perinatal Support Staff shall initiate appropriate interventions in response to the Member's identified risk status regarding weight

PSYCHOSOCIAL ASSESSMENT/RE-ASSESSMENT

The Perinatal Support Staff shall be responsible for the Psychosocial Assessment/Re- assessment which includes:
- Current living status
- Personal adjustment and acceptance of pregnancy (e.g. "Is this a wanted or unwanted pregnancy?")
- Substance use/abuse
- Member's goals for herself in this pregnancy
- Member's education, employment, and financial material resources
- Relevant information from the medical history, including physical, emotional, or mental disabilities
- Experience within the health care delivery system and/or any prior pregnancy

HEALTH EDUCATION ASSESSMENT/REASSESSMENT

The Perinatal Support Staff shall be responsible for the Health Education Assessment/Re-Assessment which includes:
- Member and family/support person(s) available to Member
- Motivation to participate in health education plans
- Disabilities which may affect learning
- Member's expressed learning needs and identified learning needs related to diagnostic impressions, problems, and risk factors
- Primary languages spoken and written
- Education and current reading level
- Current health practices (i.e., Member's religious/cultural influences potentially affecting the Member's perinatal health)
- Evaluation of mobility and residency. Transportation assistance shall be considered when the resources immediately available to the maternal, fetal, or neonate Member are not adequate to deal with the actual or anticipated condition
- Evaluation for level of postpartum self-care, infant care to include immunizations and car seat safety

Provider/Practitioner's Responsibilities

Provider/Practitioner shall be responsible for the completion of the medical/obstetrical assessment portion of the initial combined prenatal risk assessment of the pregnant Member and may utilize any of the following perinatal assessment forms:
- POPRAS
- Hollister
- ACOG

A copy of the Provider/Practitioner's completed perinatal assessment form, (POPRAS, Hollister or ACOG), **must** be forwarded to the hospital identified for Member's delivery by the Member's thirty-fifth (35th) week of gestation. Provider/Practitioner shall direct Members with identified risks to hospitals with advanced obstetrical and neonatal units. Provider/Practitioner's Medical/Obstetrical Assessment includes:
- History of previous cesarean sections

- Operations on the uterus or cervix
- History of premature onset of labor
- History of spontaneous or induced abortion
- Newborn size; small or large for gestational age
- Multiple gestation
- Neonatal morbidity
- Fetal or neonatal death
- Cardiovascular disease
- Urinary tract disorders
- Metabolic or endocrine disease
- Chronic pulmonary disease
- Neurological disorder
- Psychological illness
- Sexually transmitted diseases
- Identification of medication taken which may influence/affect health status
- HIV/AIDS Risk assessment/testing and counseling (Senate Bill 899) must be offered to all pregnant Members at initial prenatal assessment. Documentation in Member's medical record must include that assessment, testing, and counseling was offered
- Documentation must include if member "accepted" or "refused" risk assessment, testing, or counseling
- Blood Pressure

Provider/Practitioner must initiate appropriate interventions in response to any problems, needs, or risks identified during the initial combined risk assessment phase. This includes health education, nutrition, and psychosocial assessment, and document in the Member's Individualized Care Plan, accordingly.

Perinatal Support Staff Responsibilities Second (2nd) and Third (3rd) Trimester Re-assessments of the Pregnant Member:

- Perinatal Support Staff shall utilize the Combined second (2nd) and third (3rd) Trimester Re-Assessment Forms to ensure a continuous, comprehensive assessment of the Member's status in each trimester and shall update the Member's Individualized Care Plan, accordingly
- Anthropometric Assessment - Prenatal Weight Gain Grid
- Perinatal Support Staff shall obtain the Member's weight (in pounds) at each trimester
- Reassessment and plot on the Prenatal Weight Gain Grid
- Perinatal Support Staff shall compare the total amount gained since the prior assessment against the weight gain expected for the Member
- Perinatal Support Staff shall consider the results of weight assessment and dietary and clinical assessments to determine appropriate nutritional interventions

Provider/Practitioner's Responsibilities - Second (2nd) and Third (3rd) Trimester Reassessment of the Pregnant Member

- During the second (2nd) and third (3rd) trimester re-assessment phase, the Provider/ Practitioner shall be responsible to update the POPRAS, Hollister, or ACOG form, to ensure the continuous, comprehensive assessment of the Member's medical/obstetrical health status
- The POPRAS, Hollister, or ACOG form was initiated by the Provider/Practitioner at the initial combined risk assessment phase and the same medical/obstetrical assessment form shall be utilized throughout the Member's second (2nd) and third (3rd) trimester reassessment phases
- The POPRAS, Hollister, or ACOG form shall be utilized to document the Provider/Practitioner's

assessment and identify any problems/risks/needs that may have occurred or changed since the Provider/Practitioner completed the previous assessment; the information obtained by the Provider/Practitioner shall be utilized to update the Member's Individualized Care Plan, accordingly

Provider/Practitioner's medical/obstetrical assessment of the member's health status shall include, but not be limited to:

- Blood pressure, weight, uterine size, fetal heart rate, presence of any edema, and Leopold's maneuvers
- After quickening, the Provider/Practitioner shall inquire and instruct Member on completing fetal kick count after twenty-eight (28) weeks gestation
- Education and counseling on signs and symptoms of preterm labor and appropriate actions to take
- Provider/Practitioner must initiate appropriate interventions in response to any problems, needs, or risks identified during the Member's trimester re-assessment phase and document in the member's Individualized Care Plan, accordingly

COMBINED POSTPARTUM ASSESSMENT FOR THE MEMBER

Provider/Practitioner's Responsibilities Postpartum Phase

- Provider/Practitioner's postpartum assessment must occur within twenty-one (21) to fifty-six (56) days post-delivery
- Postpartum assessment two (2) weeks post C-section falls outside of this requirement
- Provider/Practitioner shall be responsible for assessing the Member's current medical/obstetrical health status by referencing the POPRAS, Hollister, or ACOG form which was initiated by the Provider/Practitioner at the initial prenatal risk assessment phase and updated with assessment information obtained during the second (2nd) and third (3rd) trimester re-assessment phases to ensure a continuous assessment of the postpartum Member. The POPRAS, Hollister, or ACOG form shall be utilized to document the Provider/Practitioner's assessment and identify any problems/risks/needs that may have occurred or changed since the previous Member assessment
- Information obtained by the Provider/Practitioner shall be utilized to update the Member's Individualized Care Plan accordingly
- Provider/Practitioner must initiate appropriate interventions in response to any problems/risks/needs identified during the Member's postpartum phase and document in the Member's Individualized Care Plan, accordingly

Perinatal Support Staff Responsibilities - Postpartum Phase [three (3) to eight (8) weeks after delivery]

- Perinatal Support Staff shall utilize the Combined Postpartum Assessment Form to provide for a comprehensive assessment of the postpartum Member in the following areas and update the Member's Individualized Care Plan
- Anthropometric Assessment - Prenatal Weight Gain Grid. Perinatal Support Staff shall obtain the Member's postpartum weight (in pounds) and plot on the Prenatal Weight Gain Grid. Perinatal Support Staff shall consider the results of the weight, dietary, and clinical assessments to determine the appropriate nutritional interventions
- Nutritional Assessment - Women's Food Frequency Questionnaire. Member shall complete the Women's Food Frequency Questionnaire that re-caps the food intake for the prior twenty-four (24) hours to determine nutritional status and any potential economic barriers to adequate nutrition for the Member and infant. Member to be evaluated for the WIC Program, Food Stamps, etc. Perinatal Support Staff shall counsel breast-feeding mothers on dietary needs of breast-feeding and management of specific breast-feeding

problems, i.e., address Member's individual concerns and needs, refer high-risk Members for appropriate intervention

Health Education Assessment

- Perinatal Support Staff shall evaluate the Member's level of health education regarding postpartum self-care and infant care and safety to include car seat, immunizations, breast-feeding, and well-child care (CHDP). Perinatal Support Staff shall identify those health education behaviors, which could promote risk to the postpartum Member or the infant
- Perinatal Support Staff shall discuss and counsel the postpartum Member on smoking cessation, substance and alcohol use, family planning and birth control methods, and provide information on Family Planning Centers, as appropriate
- Perinatal Support Staff shall identify goals to be achieved via health education interventions
- Perinatal Support Staff to discuss importance of referral of infant for CHDP exam, immunizations, and well-child care
- Perinatal Support Staff shall educate the Member on how to enroll the newborn in the Plan and how to select a PCP for the newborn

Psychosocial Assessment

- Perinatal Support Staff shall identify psychosocial behaviors which could promote a risk to the postpartum Member or the infant
- Perinatal Support Staff shall identify and support any strengths and habits oriented towards optimal psychosocial health
- Perinatal Support Staff shall identify goals to be achieved via psychosocial interventions
- Perinatal Support Staff must initiate appropriate interventions in response to any problems, needs, or risks identified in the member's postpartum phase and document in the Member's Individualized Care Plan, accordingly

Complicated/High-risk Pregnancy - Identification and Interventions

- Early identification of complicated/high-risk pregnancy is critical to minimizing maternal and neonatal morbidity
- Both Providers/Practitioners and Perinatal Support Staff shall be responsible for identifying the complicated/high-risk pregnancy and providing the appropriate intervention(s)
- Referrals to physician specialists; i.e., Perinatal Specialist, Neonatal Specialist
- Coordinating with other appropriate medically necessary services
- Coordinating with appropriate support services/agencies
- Referrals to the Local Health Department support agencies
- Coordinating with MHC Perinatal Services Staff for appropriate interventions and follow-up.
- Coordinating with MHC Medical Case Manager for appropriate interventions and follow-up through the Case Coordination/Management process of Perinatal Services

Individualized Care Plans (ICPs)

- All pregnant Members, regardless of risk status, must have an ICP
- ICPs must be initiated at first prenatal visit
- ICPs must be reviewed and revised accordingly, each trimester at the minimum, throughout the pregnancy

and postpartum phases, by the Provider/Practitioner and the Perinatal Support Staff members

ICPs must address/document the following four (4) components:

- Nutritional Assessment
- Psychosocial Assessment
- Health Education Assessment
- Medical/Obstetrical Health Status Assessment

ICPs documentation within the four (4) component areas must address the following:

- Nutritional Assessment: Prevention and/or resolution of nutritional problems. Support and maintenance of strengths and habits oriented toward optimal nutritional status and goals to be achieved via nutritional interventions
- Psychosocial Assessment: Prevention and/or resolution of psychosocial problems
- Support and maintenance of strengths in psychosocial functioning and goals to be achieved via psychosocial interventions
- Health Education Assessment: Health education strengths, prevention and/or resolution of health education problems and/or needs and medical conditions and health promotion/risk reduction behaviors, goals to be achieved via health education interventions and health education interventions based on identified needs, interests, and capabilities
- Medical/Obstetrical Health Status Assessment: Continuous evaluation of the Member's medical and obstetrical health status

ICPs must be developed from multidisciplinary information obtained and interventions initiated resulting from, but not limited to, the following:

- Prenatal Assessment profile;
- Women's Food Frequency Questionnaire;
- Prenatal Weight Gain Grid;
- Providers/Practitioners assessment to include Medical/Obstetrical Health status;
- Providers/Practitioners second (2nd) and third (3rd) Trimester re-assessment to include
- Medical/Obstetrical Health status; and,
- Perinatal Support Staff's individualized review of member and their Psychosocial, Health Education, and Nutritional Assessment results

ICPs shall serve as an effective tool for the ongoing coordination and dissemination of information on the pregnant Member's perinatal care throughout all phases of the pregnancy and postpartum (i.e., initial visit, all trimester reassessments and postpartum). For any of the multidisciplinary Perinatal Support Staff or Provider/Practitioner involved with the Member, ICPs shall serve as an identification source/summary of prioritized problems, needs, or risk conditions as identified.

- ICPs must be created and individualized for each pregnant Member
- ICPs must be created in conjunction with the pregnant Member
- ICP must clearly define who is responsible for implementing the proposed interventions and the timeframes

PREGNANCY REWARDS PROGRAM

The Pregnancy Rewards program encompasses Member outreach, and Member and provider education and awareness to facilitate the timely receipt of prenatal and postpartum care. Molina employees work to identify and implement appropriate assistance and interventions for participating Members. The main focus of the

pregnancy program is to identify pregnant women to help motivate them to complete necessary preventive exams and screenings for improved health outcomes for themselves and their new baby.

Pregnancy Rewards does not replace or interfere with the Member's physician assessment and care nor does it deviate from the Motherhood Matters® program.

Program Goals

The goals of the Pregnancy Rewards program include:

- Identify pregnant Members as early as possible in the course of their pregnancy
- Identify newly pregnant Members, or members newly accessing prenatal care
- Increase percentage of Members who receive prenatal care within the first trimester or forty-two (42) days of enrollment
- Increase percentage of Members who receive a postpartum visit twenty-one (21) to fifty-six (56) days after delivery
- Improve access to care for Members facing barriers.
- Monitor program effectiveness through the evaluation of outcomes and Member feedback.

Eligibility Criteria

Pregnancy Rewards is a population-based pregnancy rewards program, which includes all pregnant females of any age .To participate in the program, the Member must be Medi-Cal eligible and enrolled with MHC, residing in San Bernardino, Riverside, Sacramento, San Diego or Imperial County.

Referral Source

Potential participants may be identified from a number of sources including, but not limited to:

- Physician referral (Pregnancy Notification Report Form ("PNR" Form) Providers/Practitioners are required to notify MHC within seven (7) days of a positive pregnancy test by completing the PNR from and faxing toll free to (855) 556-1424. If you have any questions or need assistance, please call (877) 665-4628
- State aid categories on monthly eligibility files when available
- Member self-referral
- Internal Molina Employee referral (i.e. Member Services, Health Education, Nurse Advice Line, Community Connectors, etc.)
- Utilization Management (as a result of authorization requests or triage service calls)
- Pharmacy utilization data
- Physician Referrals
- Claims data
- Lab data
- Data from Health Risk Assessments

Program Components

1. Outreach to Members
    A. Pregnancy Notification/Identification – Molina identifies Members who are pregnant through a variety of resources
    B. Telephone outreach – Members are contacted via telephone by specially trained Molina staff using a standardized script and asked questions designed to identify if the Member is pregnant and if she needs assistance

C. Additional resources – Information on health management-related programs that the Member can 'opt-in'
D. All Members will receive assistance with scheduling provider appointments and overcoming barriers to access (e.g., transportation, language, etc.)
E. The outreach may also incorporate home health visits to help Members who struggle to complete their appointments for various reasons
F. All Members will receive a postpartum telephonic outreach to educate and assist with scheduling a postpartum visit, newborn follow-up visit and answer any questions
G. The maternity team is available to assist Members with follow up questions related to all materials distributed and refer accordingly
H. All Members will receive annual reminders for flu vaccination

MOTHERHOOD MATTERS® PREGNANCY PROGRAM

Motherhood Matters® Pregnancy Program encompasses clinical case management, Member outreach, and Member and Provider/Practitioner education to manage high risk pregnant Members. The Perinatal Case Management staff works closely with the Provider/Practitioner community in the identification, assessment, and implementation of appropriate intervention(s) for every Member participating in the program. The program comprises multi-departmental activities to ensure the coordination and delivery of comprehensive services to participating Members. The main focus of the program is on Member outreach to identify high risk pregnant women and the subsequent provision of risk assessment, education, and case management services.

Motherhood Matters® program does not replace or interfere with the Member's physician assessment and care. The program supports and assists physicians in the delivery of care to the Members. **For Members who are receiving CPSP services at the time of entry into Motherhood Matters®, the program will serve as back-up and additional support resource.**

The goals of pregnancy management program are to:

- Improve MHC knowledge of newly pregnant Members, or members newly accessing prenatal care
- Identify all pregnant Members as early as possible in the course of their pregnancy
- Improve the rate of screening pregnant Members for potential risk factors by the administration of initial and subsequent assessments
- Provide education services to high risk pregnant Members and their families
- Refer Members at high risk for poor pregnancy outcome to perinatal case management
- Provide coordinated, integrated, continuous care across a variety of settings
- Actively involve Providers/Practitioners, Members, families, and other care providers in the planning, provision, and evaluation of care for high risk Members
- Meet patients', families', and Providers/Practitioners' expectations with pregnancy care
- Improve the quality of information collection and statistical analysis; in order to assess the effectiveness of the program and to project future needs
- Monitor program effectiveness through the evaluation of outcomes

Eligibility Criteria for Program Participation and Referral Source

Motherhood Matters® is a population-based pregnancy program, which includes high risk pregnant females of any age. To participate in the program, the Member is Medi-Cal eligible and enrolled with MHC, resides in San Bernardino, Riverside, Sacramento, San Diego, or Imperial Counties and has been identified as a high-risk pregnant Member through screening.

Referral Source

Potential participants may be identified from a number of sources including, but not limited to:

- Physician referral (Pregnancy Notification Report Form ("PNR" Form) Providers/Practitioners are required to notify MHC within seven (7) days of a positive pregnancy test by completing the PNR from and faxing toll free to (855) 556-1424. If you have any questions or need assistance, please call (877) 665-4628.
- Members' self-referral.
- Member Services (as a result of member outreach calls).
- Utilization Management (as a result of authorization requests or triage service calls).
- Quality Improvement (as a result of various reports submitted monthly by IPAs/Medical Groups).
- Pharmacy utilization data
- Nurse Advice Line referrals
- Laboratory Data

Program Components

1. Assessment and Referral

Following an initial health assessment performed by the Motherhood Matters Coordinator, the risk factors are scored and based on the assessment outcome pregnant members are risk-stratified into two (2) levels:

I. Normal pregnancy - No identified risks
II. High risk pregnancy - Risk factors identified

Perinatal Case Management staff reviews all level II members for actual or potential at risk pregnancy. High-risk indicators include, but are not limited to:

- Age under eighteen (18) or over thirty-five (35)
- Unstable or high-risk social situation (inadequate shelter or nutrition; abuse)
- Current or past gestational diabetes or other medical co-morbidity
- History of preterm labor or premature birth
- History of fetal demise, stillbirth, or other poor pregnancy outcome
- Smoking, alcohol, drug, or other substance abuse
- History of behavioral health problems

Members who are positive for any of the above indicators, or have other indications as determined, are enrolled in the Motherhood Matters® program and remains in prenatal case management for detailed assessment and further evaluation and intervention(s), as appropriate. Following the completion of initial assessment, regular follow up assessments are conducted throughout the pregnancy. A postpartum depression is completed one (1) to five (5) weeks after the delivery.

2. Health Education

For those participants with identified risks that can be addressed through educational intervention, additional Member education services may be provided by a health educator and/or social worker within the Care Management team. Participants identified with nutritional risk, may also include a comprehensive nutrition assessment and the development of a meal plan by a Registered Dietitian.

3. High-risk Case Management

The case management of high-risk pregnancy incorporates an intensive process of case assessment, planning, implementation, coordination, and evaluation of services required to facilitate an individual with high-risk obstetrical conditions through the health care continuum. The program consists of a comprehensive approach toward evaluating the Member's overall care plan through an assessment and treatment planning process. The case management process comprises case triage and collaboration with treating physician(s), ancillary and other Providers/Practitioners, and development of an individual care plan.

Perinatal case management registered nurses, in conjunction with the treating physician, coordinate all health care services. This includes the facilitation of appropriate specialty care referrals, coordination of home health and DME service, and referral to support groups/social services within the Member's community. MHC's case managers work closely with Public Health Programs to ensure timely and appropriate utilization of available services (e.g., WIC) and may include California Children's Services for Members under age twenty-one (21). Additionally, case managers coordinate services with the Comprehensive Perinatal Services Program in cases where the Member is already receiving such services.

To ensure timely follow-up with the Provider/Practitioner, the database supporting the program has the capability to generate reminders for call backs for trimester specific assessments, prenatal visits, postpartum visits, and well-baby checkups.

4. Provider Education

To ensure consistency in the approach of treating high-risk pregnancy, MHC has developed clinical guidelines and pathways, with significant input from practicing obstetricians. While the guidelines originate from nationally recognized sources, their purpose is to serve as a starting point for Providers/Practitioners participating in health management systems program. They are meant to be adapted to meet the needs of Members with high-risk pregnancies, and to be further refined for individual patients, as appropriate. The guidelines are distributed to MHC network participating obstetrical Providers/Practitioners. Other methods of distribution and updating are via *Just the Fax* weekly electronic publications, continuing medical education programs, quarterly physician newsletter, and individual Provider/Practitioner contact.

New Member Outreach

Information introducing the Motherhood Matters® Perinatal Services Program, that emphasizes early entry into the program, is included in MHC's Welcome Package.

- The Welcome Package shall be mailed to all new MHC members or responsible party within seven (7) days of enrollment
- Annually updated Evidence of Coverage shall be mailed to all MHC members or responsible party.
- The Welcome Package shall be printed and distributed in appropriate threshold languages for MHC members

Focused Reviews/Studies

All compliance monitoring and oversight activities are undertaken with the goal of assisting and enabling the perinatal Provider/Practitioner to provide care and services that meet or exceed community/professional standards, Department of Health Care Services (DHCS) contractual requirements, and National Committee for Quality Assurance (NCQA) standards and that health care delivery is continuously and measurably improved in both the inpatient and outpatient/ambulatory care setting.

Obstetricians with five (5) or more deliveries require a Prenatal/OB medical record review once every three (3) years. The performance goal is eighty-five percent (85%) or above for the following categories: Format and documentation; OB/CPSOP Guidelines (Perinatal Preventive Criteria); and Continuity and Coordination of Care. Audit results are reported to the Quality Improvement Committee.

Grievances and Survey

- The QI Department utilizes Provider/Practitioner and member surveys to assess compliance with Plan standards
- The QI Department investigates, monitors, and provides follow-up to Provider/Practitioner and member grievances involving potential clinical quality issues

Findings are reported to the individual Provider/Practitioner, the Clinical Quality Improvement Committee, the Quality Improvement Committee, and/or the Professional Review (Credentials) Committee as appropriate.

NURSE MIDWIFE SERVICES

Defined by Title 22, nurse midwife services are permitted under State law and are covered when provided by a Certified Nurse Midwife (CNM). MHC will provide access to and reimbursement for CNM services under State law. Federal guidelines have been established and Members have the right to access CNM services on a self-referral basis.

Covered Services

All eligible MHC Members are eligible to receive the following limited care and services from a CNM:
- Mothers and newborns through the maternity cycle of pregnancy
- Labor
- Birth
- Immediate postpartum period, not to exceed six (6) weeks

The CNM services must be provided within seven (7) calendar days of request, based on the severity of the Member's condition.

Procedure

Referral to a contracted CNM may be made by either a Primary Care Practitioner (PCP) or by the member requesting the services.
- Minors may access a CNM in accordance with MHC Policy and Procedure, Confidential Access to Service for Minors, or applicable policy
- The CNM will work under the supervision of a physician, as defined by law

Notification

Members are notified of the availability of CNM services through their PCP or OB/GYN Providers/Practitioners. Members are also notified of availability of services through the Evidence of Coverage, which is distributed at the time of enrollment and annually thereafter.

Supervising Providers/Practitioners

Supervising Providers/Practitioners will submit claims directly to MHC, in accordance with MHC's Claim Payment Policy and Procedures. This instruction also addresses the appeal process for denial of claims (Please reference to Claims Manual).

The CNM will be credentialed through the credentialing and re-credentialing process of allied health Providers/Practitioners at MHC or subcontracted affiliated plan.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS & CHILDREN

The Women, Infants & Children (WIC) Supplemental Food Program provides an evaluation and, if appropriate, a referral for pregnant, breast-feeding, or postpartum women or parents or guardians of a child under five (5) years of age. Program services include nutrition assessment and education, referral to health care, and monthly vouchers to purchase specific food needed to promote good health for low-income pregnant, breast-feeding, and postpartum women, infants, and children under five (5) years of age with a medical/nutritional need.

Program Services

WIC participants receive a packet of food vouchers each month, which they can redeem at the local retail market of their choice, for supplemental food such as milk, eggs, cheese, cereal, and juice. WIC participants attend monthly nutrition and health education classes and receive individual nutrition counseling from registered dieticians and nutrition program assistance. WIC also refers participants to other health and social service programs. Federal law requires the WIC program to promote and support breast-feeding.

Policy

As part of the initial evaluation, Provider/Practitioners will document the referral of pregnant, breast-feeding, or postpartum women or a parent/guardian of a child under age five (5) to the WIC program. Evidence of the referral will be documented in the Member's medical record. Children will be screened for nutritional problems at each initial, routine, and periodic examination. Children and women, who are pregnant, postpartum, and breast-feeding, will be referred to the local WIC supplemental-food program. Follow-up of WIC referrals will be completed and documented at each subsequent periodic visit.

Identifying Eligible Members

Members are eligible for WIC services if they meet one (1) of the following criteria:

- Pregnant woman
- Breast-feeding woman (up to one (1) year after childbirth)
- Postpartum woman up to six (6) months after childbirth)
- Child under age five (5) years who is determined to be at nutritional risk by a health professional

To maintain eligibility, members must also:

- Receive regular medical checkups
- Meet income guidelines
- Reside in a local agency service area

Referrals to WIC

PCPs are responsible for referring eligible Members to WIC programs, providing required documentation with each referral, and coordinating follow-up care. Upon request of the PCP, MHC will assist in the coordination of the WIC referral, including assistance with appointment scheduling in urgent situations.

Referrals to WIC services must be made on one (1) of the following forms:

- PM-160, CHDP Form
- PM-247, WIC Pediatric Referral Form
- PM-247A, WIC Referral for Pregnant Women Form
- Nutritional Questionnaire
- Provider/Practitioner Prescription Pad

Federal WIC regulations require hemoglobin or hematocrit test values at initial enrollment and when participants are re-certified. These biochemical values are used to assess eligibility for WIC program benefits. Children will be referred to WIC for the following conditions:

- Anemia - Please refer to the Pediatric and Child Health Services Section of this Manual for details
- Abnormal growth (underweight, overweight)
- Underweight is defined as being in the fifth (5th) percentile of the Pediatric Standard Growth Chart as established by the American Academy of Pediatrics
- Overweight is defined as being over the one-hundred-twentieth (120th) percentile of the Pediatric Standard Growth Chart as established by the American Academy of Pediatrics

Women who are pregnant, postpartum, and/or breast-feeding will be referred to WIC according to the MHC perinatal protocols located in the Women's and Adult Health Services Including Preventive Care Section of this Manual.

Blood tests will be conducted not more than sixty (60) days prior to WIC certification and be pertinent to the category for enrollment. The following data will be collected:

- Data for persons certified as pregnant women will be collected during their pregnancy
- Data for postpartum and breast-feeding women will be collected after the termination of pregnancy

The biochemical values that are required at each certification include: WOMEN - PERINATAL, POSTPARTUM, BREAST-FEEDING:

- Hemoglobin or hematocrit values are required at each certification including:
  - Initial prenatal enrollment
  - Postpartum certification - up to six (6) weeks after delivery
  - Certification of breast-feeding women - approximately six (6) months after delivery
- Hemoglobin or hematocrit values are required at initial enrollment and with each subsequent certification approximately every six (6) months. Biochemical data is not required when:
  - An infant is six (6) months of age or under at the time of certification
  - A child over one (1) year had blood values within normal limits at the previous certification. In this case, the hemoglobin and hematocrit (H&H) is required every twelve (12) months

Assessments

All WIC eligible Members will have a nutritional assessment completed at the time of the initial visit by the PCP. Children will be screened using the following tools to assess nutritional status:

- Nutritional assessment history form
- Physical examination of height/weight

- Laboratory screening of hemoglobin or hematocrit
- Laboratory screening of blood lead levels

Nutritional education will be done by the PCP and documented in the Member's medical record. The MHC Provider Services Department will inform Providers/Practitioners of the Federal WIC anthropometric and biochemical requirements for program eligibility, enrollment, and certification.

Providers/Practitioners will complete the WIC Medical Justification Form for Members requiring non-contract special formula and state the diagnosis and expected duration of the request for the special formula. Provider/Practitioners will provide a copy of the Member's health assessment, including nutritional risk assessment, to the local WIC office after the Member's consent has been received to release this information.

Medical Documentation

It is essential that Providers/Practitioners document WIC referrals in the Member's medical records. The documentation can be a copy of the referral form and/or notes in the Member's file documenting the visit and subsequent referrals. WIC considers findings and recommendations of referrals to be confidential and declines to share information regarding individual referral findings. WIC has agreed to share aggregate data pending clarification regarding confidentiality from the Department of Agriculture. Until clarification is made, the PCP should encourage Members to inform him/her of the outcome of their WIC visit, thereby allowing the PCP to provide appropriate and consistent follow-up, noting outcomes in the progress notes of the Member's medical record.

Local Health Department Coordination

The WIC offices, through the Local Health Department, will function as a resource to MHC and Providers/Practitioners regarding WIC policies and guidelines, program locations, and hours of operation.

BREAST-FEEDING PROMOTION, EDUCATION, AND COUNSELING SERVICES

Primary Care Providers/Practitioners, Pediatric Providers/Practitioners, and Ob-Gyn Providers/Practitioners must provide postnatal support to postpartum breast-feeding mothers through continued health education, counseling, and the provision of medically necessary interventions such as lactation durable medical equipment.

Postpartum women should receive the necessary breast-feeding counseling and support immediately after delivery. Assessment of breast-feeding support needs should be part of the first newborn visit after delivery.

MHC endorses the following statement by the American Academy of Pediatrics, that "breast-feeding ensures the best possible health as well as the best developmental and psychosocial outcomes for the infant" (AAP Policy Statement, 2005). The vast benefits of breast-feeding for the infant, mother and the community have been well researched and documented. They include nutritional, developmental, immunological, psychosocial, economic and environmental benefits. It is recognized that there may be some barriers to breast-feeding due to physical or medical problems with the mother or infant, poor breast-feeding technique, or complementary feeding. All postpartum women should be offered breast-feeding resources to help them make informed choices about how to feed their babies and to get the information and support they need to breastfeed successfully. The distribution of promotional materials containing formula company logos is prohibited as per MMCD policy letter 98-10.

All pregnant Members should be referred to the Pregnancy Rewards program for information or incentives related to prenatal and postpartum services. High risk pregnant Members should be referred to the Motherhood Matters® Pregnancy Program. The Motherhood Matters® staff conduct postpartum assessments and health education to Members referred to the Motherhood Matters® Pregnancy Program. Breast-feeding promotion and counseling are included in third trimester assessment and the postpartum health assessment conducted as part of the program. Members can also be referred to lactation counselors through local WIC offices. For breast-feeding education materials to support breast-feeding Members, please contact the Health Education Department at (866) 472-9483.

Durable Medical Equipment

Lactation management aids, classified as Durable Medical Equipment (DME), are covered benefits for MHC Members. Specialized equipment, such as electric breast pumps, will be provided to breast-feeding MHC Members when medically necessary.

Human Milk Bank

Medi-Cal benefits include enteral nutritional supplemental or replacement formulas when medically diagnosed conditions preclude the full use of regular food. The provision of human milk for newborns will be arranged in the following situations:

- Mother is unable to breastfeed due to medical reasons and the infant cannot tolerate or has medical contraindications to the use of any formula, including elemental formulas

For information regarding human milk banks, please contact your local WIC office.

ADULT PREVENTIVE CARE SERVICES GUIDELINES

MHC implements programs to encourage preventive health behaviors which can ultimately improve quality outcomes. Preventive Health Guidelines (PHG) are updated annually and derived from recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians, and others. The recommended services noted in the Preventive Health and Clinical Practice Guidelines are based on clinical evidence; however, Providers/Practitioners and members should check with the Plan to determine if a particular service is a covered benefit.

- Preventive Health Guidelines: see website (www.MolinaHealthcare.com) for current and updated guidelines
- Clinical Practice Guidelines: see website (www.MolinaHealthcare.com) for current and updated guidelines

To request a hardcopy of the guideline, contact MHC's Provider Services at (855) 322-4075.

INITIAL HEALTH ASSESSMENTS (IHA)

The Primary Care Physician (PCP) has the principal role to maintain and manage his/her assigned Members. The PCP conducts the Initial Health Assessment and provides necessary care to assigned Members and coordinates referrals to specialists and health delivery organizations as needed. The IHA is a comprehensive assessment that is completed during the Member's initial encounter with a selected or assigned PCP and must be documented in the Member's medical record. The IHA enables the Member's PCP to assess and manage the acute, chronic and preventive health needs of the Member.

The Department of Health Care Services recently updated the Staying Healthy Assessment (SHA)/Individual Health Education Behavioral Assessment (IHEBA) assessment tools. All assessment questions were updated in accordance with the guidelines of the US Preventive Services Task Force and other relevant governmental and professional associations. The DHCS and MHC require providers to administer an IHEBA to all Medi-Cal managed care patients as part of their IHA and well care visits. **Members are required to have an IHA within one-hundred-twenty (120) days of enrollment with the plan.**

The goals of the SHA are to assist providers with:

- Identifying and tracking high-risk behaviors of Members.
- Prioritizing each Member's need for health education related to lifestyle, behavior, environment, and cultural and linguistic needs
- Initiating discussion and counseling regarding high-risk behaviors
- Providing tailored health education counseling, interventions, referral, and follow-up

IHA Overview & PCP Responsibilities

- All Members must have a complete IHA within one-hundred-twenty (120) calendar days of enrollment
- This assessment should be done on the Member's initial visit, will be both gender and age specific, and include a history and physical examination.
- The IHA for Members under age twenty-one (21) will be based on American Academy of Pediatrics (AAP) guidelines and will include the recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP). These preventive visits must include age specific assessments and services required by the Child Health and Disability Prevention Program (CHDP)
- The IHA for Members over age twenty-one (21) will meet the guidelines addressed in U.S. Preventive Services Task Force (USPSTF) and recommendations delineated in MHC's Preventive Health and Clinical Practice Guidelines
- The IHA must be accompanied by an age appropriate initial health education behavioral assessment, utilizing the MMCD developed "Staying Healthy" Assessment tool
- PCPs are responsible for reviewing each Member's SHA in combination with the following relevant information: Medical history, conditions, problems, medical/testing results, and member concerns; Social history, including Member's demographic data, personal circumstances, family composition, Member resources, and social support; and Local demographic and epidemiologic factors that influence risk status
- The PCP must review the assessment, provide needed counseling or other intervention, document on the assessment, and file in the Member's medical record with other continuity of care forms. The age-appropriate questionnaire must be reviewed with the Member and/or parent at least annually. Multi-lingual and age appropriate Staying Healthy assessment forms are available on the MHC website and on the DHCS website. Please refer to the below link to access this information: www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx
- The SHA is an age-appropriate questionnaire that must be administered during the Member's IHA (within one-hundred-twenty (120) days of the effective date of enrollment) and again at defined age intervals. Current Members who have not completed an updated SHA must complete it during the next preventive care office visit (e.g. well-baby, well-child, well-woman exam), according to the SHA periodicity table below.
- It is recommended that page two (2) of the completed "Staying Healthy" Assessments for age twelve (12) - seventeen (17) should be placed under the "sensitive tab" in the medical record, preventing photocopying should a parent/guardian request the record. This precaution protects the confidentiality of the minor's disclosures, according to the MMCD letter 99-07, Individual Health Behavioral Assessment

The SHA Periodicity Table and SHA administration policy is summarized in the below table:

Periodicity	**Initial SHA Administration**	**Subsequent SHA Administration / Re-Administration**		**SHA Review**
Age Groups	Within 120 Days of Enrollment	1st Scheduled Exam *(after entering new age group)*	Every 3-5 years	Annually *(Intervening years between administration of new assessment)*
0-6 mo.	✓			
7-12 mo.	✓	✓		
1-2 yrs.	✓	✓		✓
3-4 yrs.	✓	✓		✓
5-8 yrs.	✓	✓		✓
9-11 yrs.	✓	✓		✓
12-17 yrs.	✓	✓		✓
Adult	✓		✓	✓
Senior	✓		✓	✓

- Members must be informed that they may refuse to respond to any question or refuse to complete the entire IHA. Refusal must be documented in the Member's medical record. This may be done by noting on the assessment itself, signing, dating, and filing it in the medical record. When a Member refuses the IHA, the PCP must inform the Member of the benefits, risks, and suggest alternatives. The PCP must document such discussion and advice in the Member's medical record
- The results of the IHA must be documented by PCP in the Progress Notes section of the Member's medical record. The PCP may utilize an initial history and physical form that is specific to his/her practice. In the event that specific forms do not address all recommended areas, those findings are to be addressed in the Progress Notes section of the Member's medical record
- Perinatal Care Providers who cares for MHC members during pregnancy may provide the IHA through initial perinatal visit(s), and must document that the prenatal visit(s) met IHA content and timeline requirements
- MHC will provide you with resources to assist you with implementation of IHA. Contact your MHC Provider Services Representative or MHC's Health Education Department at (855) 322-4075 with your request on "Staying Healthy" Assessment assistance
- MHC contacts Members within thirty (30) calendar days of enrollment to encourage scheduling an appointment for an initial health assessment. Members are informed of the benefit in the Evidence of Coverage. The requirement is waived if the Member's PCP determines the Member's medical record contains complete and current information consistent with the IHA requirements (such as history and physical exam that is age and gender specific, evaluates risk factors, and the socioeconomic environment of a Plan Member)

Initial Health Assessment Components

IHA consist of the following:

A. Comprehensive History: must be sufficiently comprehensive to assess and diagnose acute and chronic conditions which includes, but is not limited to the following:
   1. History of Present Illness
   2. Past Medical History
      a. Prior major illnesses and injuries

b. Prior operations
c. Prior hospitalizations
d. Current medications
e. Allergies
f. Age appropriate immunization status
g. Age appropriate feeding and dietary status

3. Social History
   a. Marital status and living arrangements
   b. Current employment
   c. Occupational history
   d. Use of alcohol, drugs, and tobacco
   e. Level of education
   f. Sexual history
   g. Any other relevant social factors
4. Review of Organ Systems

B. Preventive Services
1. Adults: referenced under IHA Overview
2. Members under twenty-one (21 Years of Age: referenced under IHA Overview
3. Perinatal Services
   a. Must provide perinatal services for pregnant members according to the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG).
   b. The assessment must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit.
   c. Risks identified must be followed up with appropriate interventions and documented in the medical record.

C. Comprehensive Physical and Mental Status Exam
D. Diagnoses and Plan of Care
E. Individual Health Education Behavioral Assessment (IHEBA): the age specific and age appropriate behavior risk assessment should address the following areas:
1. Diet and Weight Issues
2. Dental Care
3. Domestic Violence
4. Drugs and Alcohol
5. Exercise and Sun Exposure
6. Medical Care from Other Sources
7. Mental Health
8. Pregnancy
9. Birth Control
10. STIs/STDs
11. Sexuality
12. Safety Prevention
13. Tobacco Use and Exposure

DENTAL SCREENING

MHC Members are entitled to an annual dental screening described in the periodic health exam schedules. Dental services, other than dental screenings, are not covered.

A dental screening will be performed at the time of all health assessments by the Primary Care Practitioner (PCP). The screening will include, but not necessarily be limited to:

- A brief dental history
- Examination of the teeth
- Examination of the gum
- Dental education

Findings of the dental screen, including education provided to the Member or family, will be documented in the Member's medical record.

Primary Care Practitioner's (PCP) Responsibility

The PCP should conduct a dental assessment to check for normal growth and development and for the absence of tooth and gum disease at the time of the initial health assessment and at each CHDP examination visit, according to the periodic health examination schedules. PCPs should perform a screening dental exam on adult Members and encourage their adult patients to receive an annual dental exam.

The PCP should perform an initial dental exam referral to a Medi-Cal approved dentist with the eruption of the child's first tooth or at twelve (12) months of age, whichever occurs first, and continue to refer the Member annually thereafter. All referrals, and the reason for the referral, should be documented. Contractor shall provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental providers are not covered under this Contract in the member's medical record.

Referral Process

A dental referral does not require prior authorization. Each PCP office is encouraged to maintain a list of local fee-for-service Medi-Cal dentists to whom Members may be referred. Members may obtain the DHCS 800 telephone number for dental referral assistance from MHC's Customer Services Department. The Denti-Cal Beneficiary line is (800) 322-6384.

VISION CARE SERVICES

MHC's Members must be provided with access to covered vision care services.

Referral

Members may be referred for vision care services by their PCP or may access vision care services on a self-referral basis. A referral for a diabetic retinal exam is not required if there is a diagnosis of diabetes. Members may obtain, as a covered benefit, one (1) pair of prescription glasses every two (2) years. No prior authorization is required for receipt of this benefit through a qualified participating Provider/Practitioner. Basic Member benefits include an eye examination with refractive services and prescription eyewear every two (2) years. Additional services and lenses are provided based on medical necessity for examinations and new prescriptions. Contracted Providers/Practitioners will order the fabrication of optical lenses from the Prison Authority Optical Laboratories for Members enrolled in the health plan.

MHC Providers/Practitioners are to refer Members to March Vision Care for vision care services at (844) 336-2724.

Routine Eye Examination

The PCP plays a vital role in detecting ocular abnormalities that require referrals for a comprehensive eye examination.
All children should undergo an evaluation to detect eye and vision abnormalities during the first few months of life and again at approximately three (3) years of age. Children between four (4) and six (6) years of age should have a comprehensive eye examination in addition to the screening performed by the PCP. Children with prescription eyewear or contact lenses should have an eye examination annually.

Children should have a comprehensive eye examination by an ophthalmologist if they have one (1) or more of the following indications:

- *Abnormalities on the screening evaluation*
- *Recurrent or continuous signs or symptoms of eye problems*
- *Multiple health problems, systemic disease, or use of medications that are known to be associated with eye disease and vision abnormality*
- *A family history of conditions that cause, or are associated with, eye or vision problems*
- *Health and developmental problems that makes screening difficult or inaccurate*

FAMILY-PLANNING SERVICES

Members are allowed freedom of choice in selecting and receiving family-planning services from qualified Providers/Practitioners. Members may access family-planning services from any qualified family-planning Provider/Practitioner without referral or prior authorization. Members may access family-planning services from any qualified Provider/Practitioner, including their PCP, contracted or non-contracted Provider/Practitioner, OB/GYN Providers/Practitioners, nurse midwives, nurse practitioners, nurse physician assistants, Federally Qualified Health Centers (FQHC), and local county family-planning Providers/Practitioners.

The right of Members to choose a Provider/Practitioner for family-planning services will not be restricted. Members will be given sufficient information to allow them to make an informed choice, including an explanation of what family-planning services are available to them.

Family-Planning Services

Access to family-planning services must be convenient and easily comprehensible to Members. Members are to be educated regarding the positive impact of coordinated care on their health outcome, so they will be more likely to access services with MHC. If the Member decides to see an out-of-plan Provider/Practitioner, the Member should be encouraged to agree to the exchange of medical information between Providers/Practitioners for better coordination of care. The following family-planning services are available to all Members of childbearing age to prevent or delay pregnancy temporarily or permanently:

- Health education and counseling necessary to understand and to make informed choices about contraceptive methods
- Limited history and physical examination
- Medically indicated laboratory tests (except Pap smear provided by a non-contracted Provider/Practitioner where the plan has previously covered a Pap smear by a plan Provider/Practitioner within the last year).
- Diagnosis and treatment of sexually transmitted diseases
- Screening, testing, and counseling of at-risk individuals for HIV treatment
- Follow-up care for complications associated with contraceptive methods issued by the family -planning

Provider/Practitioner
- Provision of contraceptive pills, devices, and supplies (including Norplant).
- Tubal Ligation
- Vasectomies
- Pregnancy testing and counseling.

The following are NOT reimbursable as family-planning services:
- Routine infertility studies or procedures
- Reversal of voluntary sterilization
- Hysterectomy for sterilization purposes only
- All abortions, including but not limited to, therapeutic abortions, spontaneous, missed, or septic abortions and related services (Note: Pregnancy testing and counseling performed by an out-of-plan family-planning Provider/Practitioner is reimbursable regardless of the member's decision to abort)
- Parking and childcare

Provider/Practitioner Responsibilities

Providers/Practitioners may not restrict a Member's access to family-planning services, nor should a Provider/Practitioner subject a Member to any prior authorization process for family-planning services. Providers/Practitioners found to be non-compliant may be subject to administrative review and/or possible disciplinary action.

The family-planning Provider/Practitioner must obtain informed consent for all contraceptive methods, including sterilization.

Procedure

- Family-planning and Sexually Transmitted Disease (STD) services will be provided in a timely manner
- Members who request an office visit for STD or family-planning services is considered as an urgent care appointment request, requiring an appointment within twenty-four (24) hours
- Family-planning services will be available through the PCP's office or through a referral from the PCP to a contracted specialist qualified to provide services, or to an out-of-network family-planning Provider/Practitioner
- For services to be rendered by contracted Providers/Practitioners within the MHC network, the PCP may initiate a referral on the same day as the Member presents. This referral does not require prior authorization from MHC's Utilization Management department
- For family-planning services requiring an inpatient stay, the PCP is to notify MHC's Utilization Management Department to coordinate care
- Should a Member request from the PCP a referral to a family-planning or STD Provider/Practitioner outside of MHC's contracted network, the PCP will educate the Member regarding the positive impact of coordinated care on his/her health outcomes, helping the Member to recognize the advantages of seeking services within MHC's network. If the Member still wants to see an out-of-plan Provider/Practitioner, the member should be encouraged to agree to the exchange of medical information between Providers/Practitioners for coordination of care
- The PCP should not refer Members to non-contracted Providers/Practitioners for family-planning, STD, or HIV services; however, the Member will be advised of his/her right of choice to family-planning Providers/Practitioners through the Evidence of Coverage
- When a Member presents, the PCP will evaluate the request for family-planning services and inform the

Member of his/her recommendations and options

Patient Information

Members will receive information to allow them to make an informed choice including:

- Types of family-planning services available
- Right to access these services in a timely and confidential manner
- Freedom to choose a qualified family-planning Provider/Practitioner

Minors

Minors have the right to seek treatment in a confidential manner. (Refer to MHC policies, Confidential Access to Services for Minors, Collection, Use, Confidentiality, and Release of Primary Health Care Information).

Documentation

The PCP will document recommendations made and options available, the consultation and counseling provided, and the response of the Member. The documentation will include any referral or recommendations.

Documentation by the Provider/Practitioner will be in compliance with MHC Policy, Medical Records Content and Documentation.

Confidentiality

- The Member must give his/her consent to any Family-planning Services assessment and treatment. A signed, informed consent will be obtained when indicated by surgical or invasive procedure
- Records are to be maintained in a confidential manner according to MHC policy, Collection, Use, Confidentiality, and Release of Primary Health Care Information
- All information and the results of the Family-Planning Services of each Member will be confidential and will not be released without the informed consent of the Member
- Appropriate governmental agencies will have access to records without consent of the Member; i.e., Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Department of Health and Human Services (DHHS), Department of Justice (DOJ)

Non-Compliance

Missed Family-Planning Service appointments within the MHC network will be addressed by utilizing MHC's policy for Failed or Missed Appointments.

Non-compliance by a Member will be acted upon by the PCP through MHC policy, Access to Health Care, which addresses follow-up and documentation of failed or missed appointments.

Coordination with Out-of-Plan Providers/Practitioners

Reimbursement to out-of-plan Providers/Practitioners will be provided at the applicable Medi-Cal rate appropriate to the Provider/Practitioner type, as specified in Title 22, Section 51501. Records obtained from out-of-plan Providers/Practitioners will be shared with the PCP for the purposes of assuring continuity of care. Out-of-plan Providers/Practitioners will be reimbursed for family-planning services only if:

- The out-of-plan Provider/Practitioner is qualified to provide family-planning services based on the licensed

scope of practices
- The out-of-plan Provider/Practitioner must provide pertinent medical records sufficient to allow MHC to meet case management responsibilities
- MHC will reimburse contracted Providers/Practitioners at contracted rates

MHC will reimburse non-contract, out-of-plan Providers/Practitioners at the Medi-Cal fee-for-service rate. Reimbursement for family-planning services will only be made if the Provider/Practitioner submits treatment records or documentation of the Member's refusal to release medical records to MHC along with billing information.

Policies and Procedures

PCPs or their staff may obtain detailed information on any MHC policy/procedure by contacting the Provider Services Department at (888) 665-4621. Available policies include, but are not limited to:
- Confidential Access to Services to Minors
- Access to Health Care
- Collection, Use, Confidentiality, and Release of Primary Health Care Information
- Safeguarding and Protecting Medical Records

SEXUALLY TRANSMITTED DISEASES (STD)

MHC Members may access care for STDs without prior authorization requirements as stated in its contracts with the California Department of Health Care Services. In accordance with Federal Law, Medi-Cal Members are allowed freedom of choice of Providers/Practitioners when seeking STD services, without prior authorization. STD services include education, prevention, screening, counseling, diagnosis, and treatment.

Participating Provider/Practitioner Responsibilities

Participating Primary Care Practitioners (PCPs) are responsible for the primary medical care of STDs. The PCP may perform services or refer Members to Local Health Department clinics, participating specialists, or upon request of the Member, to out-of-plan Providers/Practitioners. Each PCP is responsible to report certain information regarding the identification of STDs to the Local Health Department within seven (7) days of identification.

When reporting to the Local Health Department, the following information must be included:
- Patient demographics: name, age, address, home telephone number, date of birth, gender, ethnicity, and marital status
- Locating information: employer, work address, and telephone number
- Disease information: disease diagnosed, date of onset, symptoms, laboratory results, and medications prescribed

The PCP will provide and document preventive care and health education, counseling, and services at the time of any routine exam for all Members with high-risk behaviors for STDs. Access to confidential STD services by minors is a benefit of MHC.

Minors

Members age twelve (12) and over may access STD services without parental consent. MHC Policy, Confidential Access to Services for Minors, may be obtained by contacting the Provider/ Practitioner Quality Improvement Department.

Non-Participating Provider/Practitioners

MHC requests that non-participating Providers/Practitioners contact the Customer Services Department at MHC to confirm eligibility and benefits and to obtain billing instructions for MHC Members. Non-participating Providers/Practitioners are requested to contact the affiliated health plan's Member Services Department to confirm eligibility and benefits and to obtain billing instructions. The non-participating Providers/Practitioners will also be given the name of the Member's PCP to arrange for follow-up services. If the non-participating Provider/Practitioner contacts the PCP directly, the PCP is responsible for coordinating the Member's care with the non-participating Provider/Practitioner.

If the non-participating Provider/Practitioner requests Care Management services, the call will be transferred to MHC's Care Management Department. The Case Manager will then arrange for any necessary follow-up care and will coordinate with the Member's PCP as necessary.

Member Education

MHC provides Member education on STDs which includes disease-specific material, right to out-of-plan treatment, cost, assessment for risk factors, and the methodology for accessing clinical preventive services. Members are advised of these services in the Evidence of Coverage which is mailed at the time of enrollment and annually thereafter. MHC Health Education Department will send STD health education information to Providers/Practitioners upon request. See the section in this manual entitled "Health Education" for instructions on ordering materials and order forms.

Provider/Practitioner Guidelines for STD Episodes

For the purposes of providing reimbursement to the Local Health Department for sexually transmitted diseases, an episode is defined based upon the specific sexually transmitted disease diagnosed as follows:

- Bacterial Vaginosis, Trichomonisis, Candidiasis Initiation of treatment of vaginal or urethral discharge for symptoms and signs consistent with any one or a combination of these diagnoses is considered an episode, and one (1) visit is reimbursable
- Primary or Secondary Syphilis - Initial visit and up to five (5) additional visits for clinical and serological follow-up and re-treatment, if necessary, may be required for certain high-risk individuals. A maximum of six (6) visits per episode is reimbursable. Documentation should include serologic test results upon which treatment recommendations were made

NOTE: Members who are found to have a reactive serology, but show no other evidence of disease, should be counseled about the importance of returning to the Provider/Practitioner for follow-up and treatment of possible latent syphilis. For female members of childbearing age who refuse to return to the Provider/Practitioner for their care, up to six (6) visits are reimbursable for treatment and follow-up.

- Chancroid - Initial visits and up to two (2) follow-up visits for confirmation of diagnosis and clinical improvement are reimbursable
- Lymphogranuloma Venereum, Granuloma Inguinale - Based upon the time involved in confirming the diagnosis and the duration of necessary therapy, a maximum of three (3) visits is reimbursable
- Herpes Simplex - Presumptive diagnosis and treatment (if offered) constitute an episode, and one visit is reimbursable

- Gonorrhea, Non-Gonococcal, Urethritis and Chlamydia - Can often be presumptively diagnosed and treated at the first visit, often with single-dose therapy. For individuals not presumptively treated at the time of the first visit, but found to have gonorrhea or chlamydia, a second visit for treatment will be reimbursed
- Human Papilloma Virus - One (1) visit reimbursable for diagnosis and initiation of therapy with referral to PCP for follow-up and further treatment
- Pelvic Inflammatory Disease - Initial visit and two (2) follow-up visits for diagnosis, treatment, and urgent follow-up are reimbursable. Member should be referred to PCP for continued urgent follow-up after the initial three (3) visits have been provided by the LHD

Reimbursement

Participating Providers/Practitioners must bill MHC or the appropriate capitated IPA/Medical Group in accordance with their Provider/Practitioner agreement and all applicable procedures. If you are an individually contracted Provider/Practitioner rendering referred or authorized STD services, you are reimbursed at the lowest allowable Medi-Cal fee-for-service rate determined by DHCS if a specific rate has not been included in your Provider/Practitioner contract.

If the STD service is denied, for example, those patients not eligible under the Medi-Cal program, the claim will be sent to the Provider/Practitioner of service to protect the confidentiality of the Member.

If the member received STD services from a non-participating Provider/Practitioner and was required to pay out-of-pocket for the services, the Member must bill MHC or the affiliated health plan or IPA/Medical Group, according to their affiliation. The billing address is located on the back of the member's ID card.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING AND COUNSELING

MHC is responsible for promoting access to confidential HIV testing and counseling services available to its Members. MHC is to assist in the coordination of care and follow-up with the Local Health Department (LHD). MHC ensures coordination of Medical Case Management and AIDS Waiver Case Management in developing a comprehensive approach to achieve healthy outcomes for MHC Members diagnosed with AIDS or symptomatic HIV disease. MHC is responsible for ensuring that its Members have access to appropriate and confidential HIV testing and counseling services and that Providers/Practitioners are reimbursed properly for services rendered. MHC must also ensure that the collection, management, documentation, and release of information regarding HIV tests are handled in compliance with State and Federal laws and regulations. In addition, MHC must ensure the safety and confidentiality of its Members and staff. MHC's network of PCPs will perform or order confidential HIV testing, counseling, and follow-up services, when indicated. MHC Members may also receive HIV testing and counseling from a LHD or from other non-participating family-planning Providers/Practitioners.

Local Health Department Coordination

MHC will collaborate with the Local Health Department for the following:
- To develop a Memorandum of Understanding (MOU) or a cooperative agreement addressing HIV testing and counseling services
- To coordinate the development of applicable policies and procedures
- To identify strategic opportunities to share resources, which maximize health outcomes
- To routinely communicate and facilitate optimal data and information exchange
- To ensure appropriate case management collaboration
- To work to resolve conflict at the local level

Provider Training and Education
The Provider Services Department at MHC, in collaboration with the LHD, provides ongoing program education and training on HIV/AIDS services. This training provides information regarding the eligibility criteria for the AIDS Waiver Program. The MHC Provider Services Department maintains a list of all agencies providing AIDS Waiver Program services within the geographic region. The MHC Provider Services Department, in collaboration with the LHD, educates providers on the conditions that make an individual eligible for AIDS Waiver Program Services and the referral process.

PCP Responsibilities

PCPs will routinely obtain a sexual history and perform a risk factor assessment for each of their Members. When appropriate, the Provider/Practitioner will screen for HIV infection with pre and post-test counseling. The PCP's initial disclosure of HIV test results to the Member can greatly affect the Member's knowledge of, and attitude about his/her condition. Prior to disclosing results, the PCP will assess the degree to which the Member, parent, or guardian is prepared to receive the results. The PCP will consider social, cultural, demographic, and psychological factors. Disclosure and counseling will always take place face-to-face. Immediate interventions may include assessing the Member for potential violence to him/herself or others, informing the Member of available services, making referrals as necessary, and addressing the prevention of HIV. PCPs will educate the member regarding the State's HIV reporting requirements.

Confidentiality

Counseling suggestions for the HIV positive members include:
- Providing information on available medical and mental health services as well as guidance for contacting sexual or needle-sharing partners. HIV-infected individuals should be counseled with regard to safe sex, including the use of latex condoms during sexual intercourse
- Describing the symptoms of common diseases that occur along with HIV and AIDS and when medical attention should be sought

Counseling suggestions for the HIV negative member may include:
- Not exchanging bodily fluids unless he/she are in a long-term mutually monogamous relationship with someone who has tested HIV antibody-negative and has not engaged in unsafe sex for at least six (6) months prior to or at any time since a negative test
- Using only latex condoms along with a water-soluble lubricant
- Reminding never to exchange needle or other drug paraphernalia

Reporting of Test Results

The reporting of HIV test results is not mandatory at this time. However, MHC requires Providers/Practitioners to report to the Department of Health Care Services and the County Health Officer whenever a patient is diagnosed with AIDS.

When reporting AIDS cases, the report is to include the name, date of birth, address, and social security number of the patient, the name of the Provider/Practitioner and clinic, and date of the patient's hospitalization as appropriate. An AIDS Adult Confidential Case Report Form is completed for Member's age twelve (12) and over.

Screening and Testing

MHC requires the written consent of the patient prior to testing of patient's blood for antibodies to the causative agents of AIDS (HIV test). The patient's written consent is obtained by the Provider/Practitioner/designee. If blood is drawn at the Provider/Practitioner's office, the consent will be filed in the Member's medical records and the blood sample will be forwarded to the laboratory. Initial evaluation by the PCP will include a history and physical for all Members suspected of HIV infection. The member's history is key to differential diagnosis, primary prevention, and partner notification.

The following information should be obtained and documented in the Member's medical record:

- Member's sexual orientation
- Intravenous drug abuse history
- Transfusion history
- Incidents of sexual contact with a person(s) with AIDS or who subsequently developed AIDS
- History of homosexual or heterosexual promiscuity
- History of work-related exposure

The physical exam of the HIV Member will include all body systems and may prove to be entirely normal. Abnormal findings range from those completely non-specific to those highly specific for HIV infection. The Member may also present with symptoms to a large number of diseases that are commonly seen in HIV infected Members. A complete physical examination will be documented in the Member's medical record and will include:

- All body systems
- Visual acuity
- Oral cavity
- Gynecological exam

Common complaints may include:

- Systemic, i.e. fever, night sweats, weight loss, fatigue
- Gastrointestinal, i.e. nausea, vomiting, diarrhea, abdominal pain
- Respiratory, i.e. shortness of breath, cough, sinus pain
- Central nervous system, i.e. visual changes, headache, focal neurological deficits, seizures
- Peripheral nervous system, i.e. numbness, tingling, pain to the lower extremities
- Musculoskeletal, i.e. joint swelling and pain, muscle tenderness, proximal weakness

Initial laboratory evaluations may include, but are not limited to, any of the following *when indicated:*

- ELISA (Enzyme-Linked Immunosorbent Assay)
- Western Blot (after two [2] positive ELISA tests)
- CBC and blood chemistry when transaminase
- Hepatitis B and C serology
- CD4 count - absolute and percent
- Baseline serology for cytomegalovirus (CMV) toxoplasmosis, and crytoantigen
- Septum culture
- Blood culture (if temperature is greater than 38.5 C)
- Wright-Giemsa stain
- Bronchoalveolar lovage
- Rapid Plasma Reagin (RPR) or Venereal Disease Research Laboratory (VDRL), i.e. rules out Syphilis, screen for other sexually transmitted diseases as indicated

Confidentiality of Test Results
Results of blood tests to detect antibodies to the probable causative agent of AIDS (HIV test) are confidential and disclosure is limited. Results may be disclosed to any of the following persons without written authorization from the subject: To the subject of the test or the subject's legal representative, conservator, or to anyone authorized to consent to the test for the subject

Disclosure of Information

- Test results are placed in the medical record clearly marked "Confidential" for the use of the treatment team at MHC
- To a Provider/Practitioner of care who procures, processes, distributes, or uses human body parts donated pursuant to the Uniform Anatomical Gift Act
- The Provider/Practitioner who ordered the antibody test may, but is not required to, disclose
    - positive test results to a person reasonably believed to be a sexual partner or a person with whom the patient has shared the use of hypodermic needles (provided the Provider/Practitioner does not disclose identifying information about the test subject to the individual) or to the County Health Officer. He/she will not be civilly or criminally liable for doing so
- MHC providers/practitioners who disclose the results as outlined above are required to document such release, including first name and last initial of the person mentioned in the medical record of the patient, also giving the reason for the release, i.e. believed sexual partner, possible shared needles, etc.
- Prior to disclosing results to a third party, the Provider/Practitioner must first discuss the results with the patient, counsel the patient, and attempt to obtain the patient's voluntary, written consent and authorization to notify the patient's contacts
- If the Provider/Practitioner discloses the information to a contact, the Provider/Practitioner must refer that person for appropriate care

Release of HIV Test Results

In all cases, except as mentioned previously, written authorization for release of HIV test results is required.

- Such disclosure includes all releases, transmissions, dissemination, or communications whether they are made orally, in writing, or by electronic transmission
- A valid authorization to release results of a blood test to detect antibodies of HIV is to be in writing and include to whom the disclosure must be made
- Written authorization is required for each separate disclosure of test results
- HIV test results will not be released pursuant to a subpoena for medical records unless accompanied by a court order directing the release
- The current applicable Release Form will be used for all releases under this section
- All requests for release of HIV test results will be verified for appropriateness
- Providers/Practitioners and employees of MHC are not permitted to remove the HIV test from the medical record or photocopy the HIV test results under any circumstances except as heretofore described

Penalties for Improper Disclosure of Test Results

Health and Safety Code, Section 199.21, provides penalties for the negligent or willful disclosure of results of a blood test to detect antibodies to the probable causative agent of AIDS to any third party. The penalty applies if the disclosure is not authorized by the patient or by law.

- If an improper disclosure resulted from negligence there may be a fine up to $1,000 plus court costs
- If an improper disclosure resulted from a willful act, there may be a fine up to $5,000

- If an improper disclosure, whether negligent or willful, results in economic, bodily, and/or psychological harm to the subject of a test, the person who made the improper disclosure may be found guilty of a misdemeanor and fined up to $10,000 or be imprisoned in county jail for up to one (1) year, or both, and may also be liable to the subject of the test for all actual damage caused, including economic, bodily, and/or psychological harm
- Any employee who releases information regarding HIV testing, whether results are positive or negative, in violation of this policy has also breached MHC's confidentiality policy and is subject to such disciplinary action as is warranted, up to and including dismissal from employment or service

Continuing Care

As the disease progresses, and depending on any accompanying diseases the Member acquires, referrals to subspecialties will be initiated as needed. The PCP will consider management by an infectious disease specialist or HIV specialist when CD 4+ 200 cells u/L or the Member develops clinical AIDS. During the terminal phase of care, issues such as advanced directives, durable power of attorney, and hospital care will be addressed by the PCP. The Medical Case Manager will monitor, and coordinate care and services provided to HIV/AIDS Members by PCPs as well as any out-of-plan providers.

Out-of-plan Providers/Practitioners

Members may access out-of-plan Providers/Practitioners for diagnosis of HIV/AIDS. MHC will reimburse contracted Providers/Practitioners at contracted rates. MHC will reimburse non-contracted, out-of-plan Providers/Practitioners at the Medi-Cal fee-for-service rate, unless otherwise negotiated. The diagnosis, counseling, and treatment of HIV/AIDS will be reimbursed if the Provider/Practitioner submits treatment records or documentation of the Member's refusal to release records along with billing information. Medical records obtained from out-of-plan Providers/Practitioners other than the Member's PCP will be shared with the PCP for the purposes of assuring continuity of care.

If a Member refuses to release the medical records required for billing, the out-of-plan Provider/ Practitioner must submit documentation of such refusal. Properly billed claims from out-of-plan Providers/Practitioners will be paid timely and in accordance with the Knox-Keene Act (amended).

TUBERCULOSIS (TB) SCREENING AND TREATMENT AND DIRECT OBSERVED THERAPY (DOT)

The estimated number of persons in the United States with latent tuberculosis (TB) infection is ten (10) to fifteen (15) million. Studies have shown the treatment of such patients with at least six (6) months of antibiotics can significantly reduce progression to active tuberculosis. Preventive treatment is ninety percent (90%) effective when the patient compliance is good. Tuberculosis is associated with considerable morbidity from pulmonary and extra pulmonary symptoms.

Direct Observed Therapy (DOT) Services are offered by Local Health Departments to monitor those patients with active tuberculosis who have been identified by their Provider/Practitioner as at-risk for non-compliance with treatment regimen. DOT is a measure both to ensure adherence to tuberculosis treatment for at-risk Members who either cannot or likely will not follow the treatment regimen and to protect the public health.

MHC and Providers/Practitioners coordinate and collaborate with Local Health Departments (LHDs) for TB screening, diagnosis, treatment, compliance, and follow-up of members. MHC's guidelines for TB screening and treatment follow the recommendations of the American Thoracic Society (ATS), Centers for Disease

Control and Prevention (CDC), and the Advisory Committee for Elimination of Tuberculosis (ACET). MHC coordinates with LHDs for the provision of Direct Observation Therapy (DOT), contact tracing, and other TB services. Members meeting the mandatory criteria for DOT are identified and referred to LHDs.

TB screening and treatment services for Members are covered responsibilities under the Two-Plan Model Contract. MHC collaborates with LHDs to control the spread of TB and to facilitate access to TB treatment. MHC coordinates with LHDs to establish an effective coordination of care to achieve optimum clinical outcomes for members. Early diagnosis, immediate reporting to LHDs, and appropriate TB treatment are critical to interrupting continued transmission of TB. MHC informs PCPs that they must report known or suspected cases of TB to the LHDs TB Control Program Office within one (1) day of identification, per Title 17, CCR, Section 2500. PCPs will coordinate and collaborate with LHDs for TB screening, diagnosis, treatment, compliance, and follow-up of MHC Members. MHC medical policy guidelines for TB screening and treatment follow the recommendations of the American Thoracic Society ATS, CDC, and the ACET. MHC will coordinate with LHDs for the provision of (DOT), contact tracing, and other TB services. MHC Members meeting the mandatory criteria for DOT are identified and referred to LHDs. MHC will direct diagnosed Class III and Class V TB cases to the applicable LHD for treatment. The PCP is responsible for coordination of care with the LHD and for meeting any additional health care needs of the Member, unrelated to TB services.

Tuberculosis Control Strategy

MHC's TB control strategy for members include the following: continued collaboration, communication, and contracting with the LHDs in the areas of public health coordination, community education/training, Provider/Practitioner and Provider/Practitioner staff education/ training, referral process, screening/ treatment, DOT, and case management processes. The control strategy includes the following:

- Communicating with the LHDs in order to facilitate an effective TB prevention, screening, and treatment process
- Identifying and reporting of TB cases to LHD
- Providing educational programs to the Members residing in various counties
- Providing education and resources to Provider/Practitioners and Provider/Practitioner's staffs regarding the prevention, screening, identification, and treatment of TB
- Providing MHC Members diagnosed with TB with early and appropriate treatment Promoting compliance with treatment programs
- Preventing the spread of TB

Screening for Tuberculosis Infection

Screening for TB is done to identify infection in Members at high-risk for TB who would benefit from therapy. Screening is also done to identify Members with active TB disease who need treatment. An assessment of risk for developing TB must be performed as part of the initial health assessment required within ninety (90) days of enrollment with MHC. MHC collaborates with the LHD TB Control Programs to identify refugees who are possible candidates for local refugee health clinic services.

Tuberculosis Risk Assessment in Adults

For adult Members, an assessment of risks for developing TB will be performed as part of the initial health assessment required to be conducted within ninety (90) days of enrollment. TB testing must be offered to all individuals at increased risk of TB unless they have documentation of prior positive test results or currently have TB disease. High-risk individuals include:

- Persons with medical risk factors associated with TB

- Immigrants from countries with high TB prevalence
- Alcoholics
- Drug users
- Residents of long-term care facilities

Tuberculosis Risk Assessment in Children

For MHC Members under age twenty-one (21), assessment for risk factors for developing TB and tuberculin skin testing must be conducted in compliance with current American Academy of Pediatric Requirements. The risk factors include the following:

- Those who have had contact with a person(s) with infectious TB
- Those who are from, or who have parents who are from, regions of the world with a high prevalence of TB
- Those with abnormalities on chest roentgenogram suggestive of TB
- Those with clinical evidence of TB
- Children who are HIV-seropositive
- Those with immunosuppressive conditions
- Those with other medical risk factors such as Hodgkin's Disease, lymphoma, diabetes mellitus, chronic renal failure, and/or malnutrition
- Incarcerated adolescents
- Children who are frequently exposed to the following adults: HIV infected individuals, homeless persons, users of intravenous and other street drugs, residents of nursing homes, and migrant farm workers

TB Skin Testing Protocols

Mantoux tuberculin skin testing is the standard method of identifying persons infected with TB. The Mantoux test will be given and read by qualified staff. Steps of tuberculin skin testing are as follows:

- TB testing must be offered to all individuals at increased risk of TB unless they have documentation of prior positive test results or currently have TB disease
- The screening test to be used is the Mantoux tuberculin test. The multi-puncture test must not be used
- Trained personnel must read the skin test results and record the result in millimeters
- Tuberculin testing will be done by injecting five (5) Tuberculin Units (TU) of PPD (0.1 ml) intradermally
- Previous BCG Vaccination is never a contraindication to tuberculin testing
- Members with a history of previous positive PPD (Mantoux) should not be retested
- Interpretation of the test result: The test will be read forty-eight (48) to seventy-two (72) hours after the injection. In the general Member population, a reaction of greater than or equal to 10mm of induration will be considered a positive test
- Members with a positive skin test will have a chest x-ray to exclude pulmonary TB
- Members with an asymptomatic infection (positive skin test, but no evidence of disease on chest x-ray) will be treated with INH alone. In infants and children, recommended duration of INH is nine (9) months. Note: INH is given daily, 10 mg per kg, in a single dose, or 300 mg/day in adults
- Children receiving INH do not need Pyridoxine supplements unless they have nutritional deficiencies. (Pyridoxine is recommended for children and adolescents on meat or milk deficient diets, or with other nutritional deficiencies, breast-feeding infants, and women during pregnancy.)
- Immunizations - Members who are receiving treatment for TB may be given measles vaccine or other live virus vaccines as otherwise indicated unless they are receiving steroids, are severely ill, or have specific vaccine contraindications
- Adults treated with INH should have baseline liver function tests (LFT) done. LFTs should be repeated monthly. In children, the incidence of hepatitis during INH therapy is so low that routine determination of

LFTs is not recommended

- Adults under age thirty-five (35) should be treated with INH for nine (9) months if they have a positive PPD and a negative chest x-ray. In members thirty-five (35) years and over, the risk of hepatic toxicity from INH outweighs the risk of progression of TB and is not recommended

The definition of a positive tuberculin skin test is as follows:

- Greater than or equal to five (5) mm for persons known or suspected to have HIV infections
- Contact with an infectious case of TB
- Person with an abnormal chest radiograph, but no evidence of active TB
- Greater than or equal to ten (10) mm, all persons except those listed above
- Greater than or equal to fifteen (15) mm. In California, this cut off is not recognized by Public Health Departments

Tuberculin skin tests are not recommended for persons at low risk for TB infection. Tuberculin skin test conversion is defined as an increase of at least 10mm of induration from below 10mm to greater than or equal to 10mm within twenty-four (24) months of a documented negative to a positive tuberculin skin test. If the test is positive, a chest x-ray must be done. Since a positive TB test does not necessarily indicate the presence of active TB disease, an individual showing a positive TB test requires further screening with other diagnostic procedures.

If the member does not return to have his/her skin test read, follow-up will be conducted by the PCP according to the missed appointment policy and process with documentation of steps taken in the Member's medical record.

Classification of TB

CLASS	TYPE	DESCRIPTION
0	TB exposure; Not infected	No history of exposure Negative reaction to tuberculin skin test
I	TB exposure; No evidence of infection	History of exposure Negative reaction to tuberculin skin test
II	TB infection; No disease	Positive reaction to tuberculin skin test Negative bacteriologic studies (if done) No clinical or radiological evidence of TB
III	Current TB disease	*M. Tuberculosis* cultured (if done) OR Positive reaction to tuberculin skin test AND Clinical or Radiological evidence of current disease
IV	Previous TB disease	History of episode(s) of TB OR Abnormal but stable radiograph findings Positive reaction to the tuberculin skin tests Negative bacteriologic studies (if done) AND No clinical or radiographic evidence of current disease
V	TB suspected	Diagnosis pending

Preventive Therapy

The following classes of members may be eligible for preventive therapy if they have not received a prior course of anti-TB treatment. Before starting preventive therapy, active TB must first be excluded. It is essential to obtain a chest x-ray when evaluating a person for TB.

Bacteriologic studies should be obtained for all members with an abnormal chest x-ray.

- TB Class II - TB infection, no disease: a member with a positive reaction to tuberculin skin test, no clinical and/or radiographic evidence of tuberculosis, and a negative bacteriologic study
- TB Class IV - TB, no current disease: a member with a positive reaction to a tuberculin skin test, abnormal, but stable radiographic findings over a period of at least three (3) months, or the radiographic abnormalities of known duration, negative bacteriologic studies, and no other clinical or radiographic evidence of active tuberculosis

Immunizations - Members who are receiving treatment for TB can be given measles vaccine or other live virus vaccinations as otherwise indicated unless they are receiving steroids, are severely ill, or have specific vaccine contraindications.

Persons with the following conditions that have been associated with an increased risk of TB should be started on preventive therapy, regardless of age:
- Drug abuse, especially with injecting drug use
- Diabetes mellitus, especially insulin dependence
- Prolonged corticosteroid therapy
- Other immunosuppressive therapy
- Cancer of the head and neck
- Hematological and Reticuloendothelial disease
- End-stage renal disease
- Intestinal bypass or gastrectomy
- Chronic malabsorption
- Low body weight
- Malnutrition and clinical situations associated with rapid weight loss

Clinical trials have shown that daily isoniazid (INH) for six (6) - twelve (12) months is highly effective in reducing the risk of TB. Every effort will be made by the PCP and the Local Health Department TB Control Program to ensure that members adhere to preventive therapy for at least six (6) months. Every effort will be made to ensure compliance for six (6) - twelve (12) months. For close contacts with infectious members who have INH-resistant TB, preventive therapies with Rifampin (RIF) should be considered. RIF should also be considered for INH-intolerant members.

For documented recent converters who were contacts to cases with monoresistance to INH, RIF should be given for six (6) months; longer duration recommended for immunocompromised individuals.

Standard Initial Regimes

All TB cases, TB Class III, or TB Class V individuals in California should be started on a four (4) drug regimen of INH, RIF, Pyrazinamid (PZA), and Ethambutol (EMB), unless contra- indicated. The treatment may be given in three (3) ways:
- Daily treatment regime: Drugs should be given together; dosages should not be split
- Bi-weekly regime: Four (4) drug therapies, administered daily for two (2) weeks and then two (2) times a week for six (6) weeks. This sequence should then be followed by therapy with INH and RIF given two (2) times a week for sixteen (16) weeks
- Thrice weekly treatment regime: Three (3) times weekly from the beginning; all four (4) drugs must be given for six (6) months

For number one (1) above, EMB should be continued until drug susceptibility results are available and resistance to INF and RIF has been excluded. PZA is continued for the first two (2) months. RIF and INH are continued for a total of six (6) months. Intermittent therapy (see above) should only be given to directly observed therapy members. If cultures remain positive beyond two (2) months of treatment, therapy should be prolonged. Ideally, treatment should be continued at least six (6) months after the culture converts to negative.

Case Management

Management of members with suspected or diagnosed TB will be referred to the Case Management program of MHC or its affiliated health plan. The Case Management staff will notify the Local Health Department TB Control Program of the designated MHC Provider/Practitioner or staff responsible for coordination of TB care with the LHD TB Control Program. MHC will promptly notify the LHD TB Control Program of any changes in the Provider/Practitioner assigned to a confirmed or suspected TB case within seven (7) days.

The PCP must respond to requests for information from the LHD TB Control Program in a timely manner and will consult with the LHD TB Control Program about treatment recommendations and protocols, as needed. The Case Management staff, PCP, and the LHD TB Control Program collaborate in identifying barriers to member compliance with self-administered treatment. Fixed-dose combination drug preparations will be available for members on self-administered therapy, and they are strongly encouraged for treatment of adults to promote compliance.

As agreed with the Local Health Department, the LHD TB Control Program will assign a TB Case Manager (TBCM) who will:

- Assess risk of transmission within two (2) working days of case notification
- Visit the member within seven (7) working days, depending on transmission risk factors
- Initiate contact investigations, when indicated
- Assess and address potential barriers to treatment adherence
- Verify initial information and collect additional information needed to complete the TB case report
- Visit the member as needed to assess and ensure treatment adherence
- Promptly notify MHC of assignment or change of the TBCM
- Respond to information requests from the PCP in a timely manner

Reporting

PCPs will comply with all applicable State laws and regulations pertaining to the reporting of confirmed and suspected TB cases to the LHD. The PCP will report known or suspected cases of TB to the LHD TB Control Program within one (1) day of identification. Reporting will be done in accordance with MHC Confidential Morbidity Reporting policy.

PCPs will promptly submit treatment plans, including dosage changes, to the LHD with updates at regular intervals as requested by the LHD until treatment is completed.* PCPs will notify the LHD when there are reasonable grounds to believe that a Member has ceased treatment. Such grounds include Member's failures to keep appointments, relocation without transferring care, or discontinuation of care. The LHD Local Health Officer may require MHC Providers/Practitioners at any time to report any clinical information deemed necessary including the prompt reporting of drug susceptibility by the Local Health Officer to protect the Member's health or the health of the public.

*NOTE: This is not applicable if the LHD is serving as the primary treatment center for the TB Member.

Referrals

The PCP will identify Class III and Class V TB cases and will route a copy of the referral form to the LHD TB Officer. A copy of the referral form will also be sent to the MHC Utilization Management Department.

The PCP may make a referral to MHC or the subcontracted affiliated plan's Utilization Management Department for case management of services for Members who are repeated no-shows for appointments. If the Case Manager determines that the Member is considered lost to medical follow-up, the health plan's Case Manager will notify the LHD.

Members diagnosed with TB must be referred by the PCP to the LHD and the health plan's Utilization Management Department.

The following Members may be appropriate for referral to the LHD and the health plan's Utilization Management Department:

- Substance abusers
- Persons with major mental health disease
- Elderly Persons
- Homeless Persons
- Formerly incarcerated person
- Persons with slow sputum conversion
- Persons with slow/questionable clinical adherence
- Persons with adverse reaction to TB medication
- Persons with poor understanding of their disease process and management
- Persons with language and/or cultural barriers

Contact Investigation and Treatment

PCPs will cooperate with the LHD TB Control Program in conducting contact and outbreak investigations involving MHC members. The Case Management Department will be available to facilitate, and if necessary, direct the coordination efforts between LHD TB Control Program and the contracted Provider/Practitioners.

Contracted Provider/Practitioners must provide appropriate examination treatment to MHC Members identified by the LHD as contacts in a timely manner, usually within seven (7) days. Examination reports will be reported back to the LHD in a timely manner. PCPs and/or the Case Management Department will promptly notify the LHD when contacts of MHC members are referred to the LHD TB Control Program for examination.

Educational Material

Educational material may be obtained for Members from various resources including, but not limited to:

- MHC Health Education Department Telephone: 562-499-6191 ext. 127524
- American Academy of Pediatrics, "Patient Medication Instructions: Isoniazid" Telephone: (800) 433-9016
- American Lung Association, "Facts about Tuberculosis". Telephone: (800) 586-4872
- Krames Communications, "Understanding Tuberculosis". Telephone: (800) 333-3032
- American Thoracic Society, 61 Broadway, New York, 10006-2755. (212) 315-8600
- U.S. Centers for Disease Control and Prevention/National Centers for Prevention Services
- Division of Tuberculosis Elimination, 1600 Clifton Rd. NE Mail Stop E, Atlanta, Georgia 30333, Telephone: (404) 639-8135

The MHC Education, Provider Services, and Care Management Departments will cooperate with the LHD TB Control Program to make health education resources available to MHC Members, Provider/Practitioners, and Provider/Practitioner's staff. This includes education to Providers/ Practitioners and Provider/Practitioner's staff on how to perform and interpret TB screening tests.

Direct Observation Therapy (DOT) for TB is not a covered service but is offered directly by the LHD. Any claims for DOT are to be submitted to the Medi-Cal field office, not to MHC.

DOT Referrals to LHDs

When a PCP identifies a TB patient who is at-risk for compliance with his or her treatment regime, the PCP will fax a copy of the DOT referral form obtained from the LHD to the Control Officer. The LHD must be notified when the PCP has reasonable grounds to believe that a patient has ceased treatment, failed to keep an appointment, has adverse drug reactions, relocated without transferring care, and/or has discontinued care.

The following members with diagnosed TB must be referred for DOT services:
- Members having multiple drug resistance (defined as resistance to INH and RIF)
- Members whose treatment has failed
- Members who have relapsed after completing a prior regime
- Children
- Adolescents
- Noncompliant individuals

Members with the following conditions should be considered for referral for DOT:
- Substance abusers
- Persons with major mental health disease
- Elderly Persons
- Homeless Persons
- Formerly incarcerated person
- Persons with slow sputum conversion
- Persons with slow/questionable clinical adherence
- Persons with adverse reaction to TB medication
- Persons with poor understanding of their disease process and management
- Persons with language and/or cultural barriers

Follow-up Care

PCPs are required to coordinate with the LHD TB Control Officer and to provide follow-up care to all Members receiving DOT services. PCPs should inform the LHD TB Control Program of any changes in the Member's response to the treatment or drug therapy. PCPs will receive a periodic report from the LHD TB Control Program, which advises them of each Member's treatment status. The LHD TB Control Program will send a copy of the Member's medical record and final status report upon completion of the DOT services to the PCP.

The PCP will arrange for the Member to receive a follow-up appointment in order to develop a follow-up treatment plan. The PCP will follow-up if the patient is a no-show for the scheduled appointment through telephone or letter and will document such follow-up effort in the Member's medical record. The PCP will notify the LHD TB Control Program if the Member continues to miss follow-up appointments.

8.3 HEALTHCARE SERVICES: PEDIATRIC & CHILD HEALTH SERVICES

CHILDREN'S PREVENTIVE SERVICES INCLUDING CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP) SERVICES

Children's Preventive Services

The Children's Preventive Services program is a preventive well-child screening program for children and adolescents who are twenty-one (21) years of age and under. The Child Health and Disability Prevention (CHDP) provides complete health assessments for the early detection and prevention of disease and disability in children. The program ensures that eligible children receive periodic health assessments and have access to ongoing health care from a medical home.

Physician Certification (Suggested)

CHDP certification is provided at no cost by the county CHDP Program and usually involves an interview and office evaluation. Non-CHDP certified physicians may contact the State directly or the MHC Provider Services Department at (855) 322-4075 for assistance to help facilitate this process.

Appointments

Well child preventive care appointment with PCP should be scheduled within seven (7) working days of the request.

Components of Health Assessment

A CHDP provider conducts a complete health assessment on all of the following:

- Health history Developmental assessment
- Unclothed physical "head-to-toe" examination
- A Vision testing
- A Hearing testing
- A Dental assessment of mouth, teeth, and gums
- A Nutritional assessment
- Laboratory screening tests appropriate to age/sex, (e.g. anemia, diabetes and urinary tract infections)
- Tuberculin test
- Sickle cell trait test, when appropriate
- Blood lead test per CHDP guidelines
- Immunization(s)
- Anticipatory guidance as delineated in the CHDP Health Assessment Guidelines
- Appropriate health education, including the harmful effects of using tobacco products and exposure to secondhand smoke

Members three (3) years of age or older are referred annually for routine dental care. A provider can directly refer the Member to a dentist or call (800) 322-6384.

Referrals and Coordination of Care

One of the goals of the CHDP program is to find any medical, dental, nutritional and developmental problems that a child may have before the problems become too severe for treatment. Once a medical, dental, nutritional or developmental problem is identified during CHDP health exam, the child may need further diagnosis and/or treatment of that problem. If the child needs a specialty care, such as optometrist or a dentist, the CHDP provider is obligated to make the referrals to assist the family to obtain the care their children need. The PCP is responsible for the supervision of practitioner extenders, ongoing care, and the coordination of care for all services that the Member/child receives. Medical Case Managers are available to provide care coordination if indicated and requested by the PCP.

MHC will provide transportation to these appointments at the Member's request. Assistance with arrangement for transportation is available through the health plan contracted vendor, Secure Transportation, by calling (844) 292-2688.

Obtaining Consent

Physicians must obtain the voluntary written consent of the Member (if over eighteen [18] years) or parent/guardian (if under eighteen [18] years) before performing a CHDP exam. Consent is also required for any release of information.

If the member or parent/guardian refuses to have the exam or any portion of the exam performed, this information must be documented in the Member's medical record.

Certification for School Entry

California State law requires that a child entering first grade must provide their schools with a certificate documenting receipt of a health assessment or a waiver of the assessment signed by the parent or a legal guardian. A child's personal physician may certify the individual for school entry if there is documentation that the physician has performed a physical examination and provided ongoing care during the eighteen (18)-month period prior to or within ninety (90) days following entrance into the first grade. The medical care must have included all applicable health assessment procedures. Providers should supply the parent or guardian of a child entering kindergarten or the first grade with a Report of Health Examination for School Entry Form (PM 171A) to show that the child has received the appropriate health assessments. Providers must supply certification for all children whether or not the CHDP program reimburses for the health assessment.

The CHDP program and local schools urge parents to schedule a health assessment for their child upon entry into kindergarten. If the parent or guardian refuses a health assessment, the parent or guardian must submit a waiver to the school.

Follow-Up for Missed Appointments

For Members who are a "no-show" at the time of their appointment(s), the Member (parent/guardian) should be followed-up with a telephone call and, if necessary, a letter from the physician's office to schedule another appointment. Documentation of the telephone call or a copy of the letter must be maintained in the Member's medical record.

All physicians who deliver care to eligible CHDP Members must submit services through encounter or claims forms.

An encounter or claim must be completed for each child who receives a CHDP health assessment. All encounters or claims form must be complete and accurate. Incomplete or inaccurate encounters or claims forms will be rejected or denied.

IMMUNIZATIONS

The provision of immunizations to children is an essential component of the comprehensive periodic health assessment required for Members under age twenty-one (21). PCPs are responsible for the administration of immunizations to their patients. Immunization services may be accessed during any PCP visit. MHC does not require rescheduling of visits for immunizations for immediate evaluation unless the child has a medical contraindication to receiving immunizations at the time of his/her visit to the PCP. Local Health Departments (LHDs) may also administer immunizations to MHC Medi-Cal Members. Go to www.cdc.gov to view the childhood immunization requirements. A sample Vaccine Administration Record for Children and Teens can also be found in Section 19, Exhibit 19M.

Additional information addressing protocols for care coordination and patient follow-up can be found in the Adult Preventive Care and Children's Preventive Services sections of this Manual.

MHC Preventive Care Guidelines (PHGs) are derived from recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians, and others. They are updated annually. Age specific PHGs for members are available on the MHC webpage at: www.MolinaHealthcare.com. You may request a copy by contacting Provider Services at (888) 665-4621.

Participating Providers/Practitioners

PCPs are available to administer immunizations during routine office hours. The PCP also has the responsibility of updating the immunization card supplied by the Local County Health Department. Members are encouraged by MHC to set up evaluations for initial health assessments and immunizations during the first one-hundred-twenty days (120) of enrollment with MHC. MHC sends members welcome and reminder letters advising them of this service. Members will receive written notice from the PCP to prompt members to come in for needed immunizations.

At each visit the PCP will inquire if the Member has received immunizations from another Provider/Practitioner. The PCP will also educate Members regarding their responsibility to inform their PCP if they receive immunization elsewhere, i.e., non-plan Providers/Practitioners, LHD, etc. When a Member experiences complication (e.g., infection or abscess), Members should contact their PCP for follow-up care just as they would with any other medical condition or concern.

Upon request, the LHD will provide technical assistance, training, and material related to immunizations for MHC Providers/Practitioners. LHDs will assist MHC in their outreach efforts by conducting public education campaigns regarding immunizations. Provider/Practitioner bulletins will include updates of information on immunizations. Providers/Practitioners will be encouraged to participate in the Vaccines For Children (VFC) Program which is a Federally funded program that provides free vaccines for eligible children and distributes immunization updates and related information to participating Providers/Practitioners. PCPs will maintain a current medical record on all members addressing applicable immunizations, notifications, and immunization services provided by an out-of-plan Provider/Practitioner. The PCP will cooperate with the out-of-plan Provider/Practitioner when requested to share Member's immunization history. The PCP will document

diligent effort in assessing the actual immunization status of the MHC member prior to any immunization services.

Local Health Department (LHDs)

In accordance with Department of Health Care Services (DHCS) guidelines, MHC will reimburse LHDs for certain immunizations and services without prior authorization. MHC requires that the LHD contact the Member's PCP or Molina's Member Services Department to confirm eligibility and benefits before administering the immunization.

Member Identification

All Members are encouraged to maintain a current immunization status. Members requiring immunizations are identified through the following sources:

- Initial health assessments
- Primary care practitioners (PCPs) and specialists
- Quality Improvement Department
- Member Services Department
- Utilization Management Department
- Emergency room/urgent care facilities
- Local Health Departments
- Claims and encounter data
- Provider Service Department through Provider/Practitioner inquiries
- Members
- Health Education Department
- Schools

Member Outreach and Education

MHC's Member outreach and health education efforts for both pediatric and adult immunization concentrate on informing Members about the necessity of immunizations. The MHC Health Education Department distributes Member education via a Member newsletter, website and other educational materials that include information promoting immunizations. The PCP is responsible to ensure the Member is up to date with immunizations.

Promoting Access to Care

MHC promotes appropriate access to care as well as immunizations by offering Provider/ Practitioner educational materials and Provider Online Directory on www.MolinaHealthcare.com. Members also have access to twenty-four (24) hour Nurse Advice service, which includes answering questions on immunizations, and other health concerns.

Reporting of Vaccine Preventable Diseases

MHC will assist LHDs in educating Providers/Practitioners, including laboratories, about their responsibilities to report vaccine-preventable (and other infectious) diseases according to California Health and Safety Code regulations.

The PCP and health plans will cooperate and assist LHDs in informing Providers/Practitioners of reported disease outbreaks and implementation of control procedures.

Please refer to MHC Policy and Procedure titled QM 41, Confidential Morbidity Reporting to Public Health, for details. This report can be obtained by contacting the Provider Services Department of MHC. Information regarding Confidential Morbidity Reporting is located in the Tuberculosis section of this Manual.

Public Health Coordination

MHC has collaborated with Local Health Departments to:

- Negotiate the Memorandum of Understanding
- Develop and coordinate policies and procedures
- Provide in-service training to internal staff and contracted Providers/Practitioners

VACCINES FOR CHILDREN PROGRAM

Vaccine for Children (VFC)

The provision of immunizations to children is an essential component of the comprehensive periodic health assessment required for Medi-Cal Members under age twenty-one (21). Medi-Cal Providers/Practitioners are encouraged to participate in the Vaccine for Children (VFC) Program. This Federally and State funded program furnishes free vaccines in bulk to enrolled Providers/Practitioners. All Medi-Cal eligible children may receive these vaccines.

Becoming a VFC Provider

Download and review the program's Provider Enrollment Packet from www.eziz.org. Complete enrollment forms and submit them to VFC. You may also FAX your request to VFC's Customer Service Center at (877) 329-9832 to request paper-based Provider Enrollment Packets. Be sure to include the name and mailing address of the person to whom the packet should be sent. For more details see our enrollment section at www.eziz.org.

Once your application is received, VFC reviews the paperwork for completion, conducts license verifications, and assigns the enrollment request to a VFC Representative in your region to conduct a New Provider Enrollment Site Visit. Once a New Provider Enrollment Site Visit is completed, and VFC has verified your practice is ready to receive and store VFC-supplied vaccines (vaccine storage units meet program requirements), VFC will assign your practice a unique Provider Identification Number (PIN), complete your enrollment, and issue a welcome letter to confirm enrollment. For more information on California VC Program, visit the website at www.eziz.org or contact VFC at: Phone: (877) 243-8832; Fax: (877) 329-9832.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a Medi-Cal benefit for children under the age of twenty-one (21). The EPSDT benefit provides a comprehensive array of preventive, diagnostic, and treatment services. Molina is required to provide coverage of any services listed in section 1905(a) of the federal Social Security Act to children who are eligible for EPSDT services when the services are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. Services must also be provided when medically necessary to prevent disease, disability, and other health conditions or their progression, prolong life, and promote physical and mental health and efficiency. The determination of whether a service is medically necessary for an individual child must be made on a case-by-

case basis, taking into account the particular needs of the child. Molina will consider the child's long-term needs, not just what is required to address the immediate situation. Molina considers all aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders. The EPSDT benefit is more robust than the state Medi-Cal benefit package provided to adults and is designed to ensure that eligible children receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. Molina providers will follow Prior Authorization guideline, Authorization Process, as long as the guidelines do not contradict or prove to be more restrictive than the federal statutory requirement.

Appropriate EPSDT services are to be initiated in a timely manner, as soon as possible but no later than sixty (60) calendar days following either a preventive screening or other visit that identifies a need for follow- up. EPSDT services include the following:

- Screening services provided "at intervals that meet standards of medical and dental practice, and at such other medically necessary intervals to determine the existence of physical or mental illnesses or conditions." Screening services must at a minimum include: a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level taking into account age and risk factors); and health education (including anticipatory guidance). In addition, screening services include any other encounter with a licensed health care provider that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition
- Vision services provided at intervals which meet reasonable standards of medical practice and that shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses
- Dental services provided at intervals which meet reasonable standards of dental practice to determine the existence of a suspected illness or condition and at a minimum includes treatment for relief of pain and infections, restoration of teeth, and maintenance of dental health
- Hearing services provided at intervals which meet reasonable standards of medical practice to determine the existence of a suspected illness or condition and, at a minimum, includes diagnosis and treatment for defects in hearing, including hearing aids
- Other necessary health care, diagnostic services, treatment, and measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the California state plan or are covered for adults

Members under the age of twenty-one (21) must receive EPSDT screenings designed to identify health and developmental issues, including Autism Spectrum Disorder (ASD) as early as possible. Molina is responsible for providing medically necessary BHT services for children with that meet eligibility criteria for services. The EPSDT benefit provides all medically necessary services as described under Title 22, CCR, Section 51184 and Title 9, CCR, Sections 1820.205 and 1830.210 that may be referred to as "EPSDT Supplemental Services" in the Molina contract with the Department of Health Care Services (DHCS).

EPSDT Supplemental Services:

- Molina is required to cover and ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services for individuals under the age of twenty-one (21) including EPSDT Supplemental Services. The EPSDT benefit includes case management and targeted case management services designed to assist children in gaining access to necessary medical, social, educational, and other services. Molina must ensure that comprehensive case management is provided to each beneficiary. Molina maintains procedures for monitoring the coordination of care provided to beneficiaries, including but not limited to all medically necessary services delivered both within and outside the Molina provider network

- Dental services are carved-out. The PCP will include dental screenings as a part of the initial health assessment. Dental screening/oral health assessment must be performed as part of every periodic assessment. Members will be referred to appropriate Medi-Cal dental providers. Molina will provide prior authorization for medical services required in support of dental procedures
- Molina must ensure that the criteria set forth in Title 22, CCR, Section 51340.1 are met when approving the following EPSDT services: hearing services, onsite investigations to detect the source of lead contamination, and pediatric day health care services. In addition, MCPs must comply with the Americans with Disabilities Act mandate to provide services in the most integrated setting appropriate to the individuals
- Speech therapy, occupational therapy, and physical therapy services are exempt from the benefit limitations. Molina provides speech therapy, occupational therapy, and physical therapy services when medically necessary to correct or ameliorate defects discovered by screening services, whether or not such services or items are covered under the state Medi-Cal plan
- Molina will provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation (NEMT) and non-medical transportation (NMT), to and from medical appointments for medically necessary services. Molina is also responsible for providing NMT to obtain covered Medi-Cal medical, dental, mental health and substance use disorder services. Molina will make the best effort to refer and coordinate NEMT for non-covered services. In addition, Molina must refer for and coordinate NMT to and from appointments for all Medi-Cal services that are carved-out, including specialty mental health, substance use disorder, dental, and any other services provided through the Medi-Cal fee-for-service (FFS) delivery system. Molina will provide transportation for the parent or guardian when the member is a minor. Molina does not transport unaccompanied minors except in the event that the appointment is for a service that does not require parental consent, as defined by state and federal law

For members under the age of twenty-one (21), the PCP will:

- Follow The Patient Protection and Affordable Care Act (ACA) mandated use of the current American Academy of Pediatrics periodicity schedule and Bright Futures guidelines and anticipatory guidance when delivering the EPSDT benefit, including but not limited to, screening services, vision services, and hearing services
- Provide all age specific assessments and services
- Provide screening, preventive, and medically necessary diagnostic and treatment services
- The PCP may request Prior Authorization for EPSDT supplemental services through the Molina Prior Authorization process. Any contracting Molina practitioner, including a physician, clinic, home health agency, medical equipment supplier, psychologist, speech therapist, or audiologist, may provide EPSDT supplemental services

Molina Case Management Services

- Molina Case Management Department will assist in the coordination of EPSDT Supplemental Services, including carve-out services:
    - Molina Case Management Department will assist in making referral to carve-out programs such as CCS, Regional Center, HCBS waiver program, Medi-Cal field office (organ transplants) or practitioner of other “carve-out” services such as dentists or mental health practitioner
    - Where another entity—such as a local education agency (LEA), Regional Center, or local governmental health program—has overlapping responsibility for providing services to an individual under the age of 21, Molina Case Management Department will assess what level of medically necessary services the individual requires, determine what level of service (if any) is being provided by other entities, and then

coordinate the provision of services with the other entities to ensure that Molina and the other entities are not providing duplicative services

- Molina Case Management Department will assist with appointment scheduling assistance and necessary transportation, including NEMT and NMT, to and from medical appointments for the medically necessary services that Molina is responsible for providing, pursuant to contracts with DHCS. In addition, Molina must refer for and coordinate NMT to and from appointments for all Medi-Cal services that are carved-out, including specialty mental health, substance use disorder, dental, and any other services provided through the Medi-Cal fee-for-service (FFS) delivery system

CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age twenty-one (21) with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. The care is delivered by CCS paneled Providers and Practitioners.

MHC Primary Care Practitioners are responsible for performing all preliminary testing and examination to determine a member's diagnosis or condition and for sufficiently documenting the information to support the diagnosis in the member's medical record. In accordance with CCS eligibility criteria, potentially eligible members are referred by the PCP or specialist physician to the CCS program. Providers are to refer a member to the CCS Program within one working day of a suspicion of the presence of a CCS eligible condition. Any Provider/Practitioner, family member, or other interested party may make a referral to CCS.

The PCP is responsible to provide all Medically Necessary Covered Services for the member's CCS eligible condition until CCS eligibility is confirmed. Once eligibility for the CCS program is established for a Member, the PCP shall continue to provide Basic Case management, all Medically Necessary Covered Services that are unrelated to the CCS eligible condition. If the local CCS program does not approve eligibility, the PCP remains responsible for the provision of all Medically Necessary Covered Services to the Member.

Eligibility Criteria

A medical eligibility criterion for CCS is based on a combination of CMS approved diagnostic and procedural coding categories and the presence of certain qualifying conditions. The listing by CMS approved diagnostic and procedural coding categories is a guide for participating Providers/Practitioners to identify potential CCS eligible conditions.

Who Qualifies for CCS?

The program is open to anyone who:

- Is under twenty-one (21) years old;
- Has having a medical condition that is covered by CCS;
- Is a resident of California;
- And has one of the following:
  - family income of $40,000 or less
  - out-of-pocket medical expenses expected to be more than twenty (20) percent of family's adjusted gross income
  - a need for an evaluation to find out if there is a health problem covered by CCS
  - was adopted with a known health problem that is covered by CCS

- a need for the Medical Therapy Program
- Medi-Cal, with full benefits

What Medical Conditions Does CCS Cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. Listed below are categories of medical conditions that may be covered and some examples of each:

- Infectious Disease Neoplasms
- Endocrine, Nutritional, and Metabolic Diseases, and Immune Disorder
- Diseases of the Blood and Blood-Forming Organs Mental Disorders and Mental Retardation
- Diseases of the Nervous System
- Diseases of the Eye
- Diseases of the Ear and Mastoid
- Diseases of the Circulatory System
- Diseases of the Respiratory System
- Diseases of the Digestive System
- Diseases of the Genitourinary System
- Diseases of the Skin and Subcutaneous tissue
- Diseases of the Musculoskeletal System and Connective Tissue
- Congenital Anomalies
- Perinatal Morbidity and Mortality
- Accidents, Poisonings, Violence, and Immunization Reactions

Special Programs

Several CCS programs are mandated for special segments of the county population and are described below. These are funded separately from the general CCS Program and have different policies and procedures to determine eligibility. The special therapy program usually operates within the public-school context to provide long-term physical and occupational therapy.

CCS Application Form

Referrals to CCS must include medical documentation from the PCP or specialist. The referring Provider/Practitioner should also provide a CCS Application Form to the parent or guardian of a potentially eligible child and assist in the completion of the forms, if required. MHC Case Managers are also available to assist, as requested. If the family does not agree to a CCS referral, the MHC Case Manager, in conjunction with the Medical Director, will work with the PCP to develop a comprehensive case management plan to identify other available programs and services and to coordinate referrals.

Acceptance into CCS Program

If the Member is accepted into the CCS Program, the referring Provider/Practitioner and the member's family receives a Notice of Action from the CCS Program.

OVERVIEW OF REFERRAL PROCESS

Initial referrals of Members with CCS eligible conditions may be made to the local CCS program by telephone, same-day mail or fax, if available. The NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR) form (DHCS 4488 (09/15)) shall be filed out completely and accurately, following the instructions included. The submission shall include supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.

Inpatient Referrals

Hospitals are responsible for making referrals for patients with CCS-eligible conditions admitted to their institutions. Hospitals should fax a copy of the admission History and Physical with referral and Discharge Summary as soon as available even if the admission was prior authorized. Authorizations for unexpected admissions will ordinarily be effective beginning the date that CCS receives notification. CCS must be notified by the next working day following the admission date. The same timeliness rules apply to requests for extending a previously authorized length of stay. Justification of continued hospitalization must accompany extension requests. A list of CCS Approved Hospitals can be found on the DHCS website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx

Authorizations

After CCS eligibility is confirmed, the patient may be directed to an appropriate CCS approved CCS paneled Provider/Practitioner(s). Authorizations are sent by the CCS Program to Providers/Practitioners. CCS reimburses only CCS-paneled providers and CCS-approved hospitals within MHC's network; and only from the date of referral. All authorizations and are for care related to the CCS eligible condition only.

Authorization for payment shall be retroactive to the date the CCS program was informed about the Member through an initial referral by MHC or a contracted Provider. In an emergency admission, MHC or Contracted network physician shall be allowed until the next business day to inform the CCS program about the potentially eligible Member. Authorization shall be issued upon confirmation of panel status or determined to meet the CCS standards for paneling.

PCP Monitoring Process

Once eligibility for the CCS program is established for a Member, the PCP continues to provide Basic Case Management, and all Medically Necessary Covered Services, including Initial Health Assessment (IHA), and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings that are unrelated to the CCS eligible condition. If the local CCS program does not approve eligibility, the PCP remains responsible for the provision of Basic Case Management and all medically necessary diagnostic, preventive and specialty referrals for treatment services, including Initial Health Assessment (IHA), and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings. Molina audits PCP compliance with these requirements through regularly requesting attestations of compliance, and by performing monthly PCP file audits.

EARLY START PROGRAM

The California Early Intervention Services Act, known as Early Start, is designed for children with developmental delays and disabilities or those at high-risk for developmental disabilities who are under three (3) years of age.

Infants and toddlers from birth to age thirty-six (36) months may be eligible for early intervention services through Early Start if, through documented evaluation and assessment, they meet one of the criteria listed below:

- Have a developmental delay of at least thirty-three percent (33)% in one or more areas of either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing; or
- Have an established risk condition of known etiology, with a high probability of resulting in delayed development; or
- Be considered at high risk of having a substantial developmental disability due to a combination of biomedical risk factors of which are diagnosed by qualified personnel California Government Code: Section 95014(a); California Code of Regulations: Title 17, Chapter 2, Section 52022

The goal of the Early Start Program is to promote and facilitate early identification and access to service delivery for eligible infants and their families. Regional Centers (RCs) and Local Education Agencies (LEAs) are designated as the local agencies to receive referrals, evaluate eligibility, conduct assessments for special needs, prepare an Individualized Family Service Plan (IFSP), and manage coordination of delivery.

Identification of Condition

PCPs shall refer members to the Early Start Program at the local Regional Center for local resources which may include parent support groups; health care providers with knowledge about early intervention and disabilities; special education, early intervention and preschool programs; regional center contacts and vendor services; advocacy organizations; and other related resources for infants and toddlers with special needs and their families.

The MHC PCP shall coordinate all medical services rendered to eligible Member.

The PCP or the Member's family may make a referral to the Regional Center (RC) located nearest the Member's place of residence. The MHC CCS staff will assist with the referral process as requested by the PCP or Member's family.

The PCP shall complete an intake and assessment for Member's age birth thirty-six (36) months with, or suspected to have a developmental disability:

- Children shall receive a complete medical evaluation to confirm the diagnosis and determine the genetic and/or non-genetic etiology. This may include, but not be limited to:
  - Prenatal/perinatal history
  - Developmental history
  - Family history
  - Metabolic and chromosomal studies
  - Specialty consultations as indicated

- Regional Center Prevention Program - Medical Factors, Guidelines
  - Prematurity <thirty-two (32) weeks gestation or low birth weight <1,500 grams
  - Small for gestational age, below the 3rd percentile.
  - Severe respiratory distress requiring assisted ventilation for >forty-eight (48) hours during the first twenty-eight (28) days of life.
  - Asphyxia neonatorum associated with five (5) minutes apgar of three (3) or less.
  - Hyperbilirubinemia requiring exchange transfusion.
  - Severe and persistent metabolic abnormality

- Neonatal seizures or nonfebrile seizures during the first three (3) years of life
- Central nervous system lesion or abnormality
- Central nervous system infection
- Serious biomedical insult which may affect developmental outcome
- Multiple congenital anomalies or genetic disorders which may affect developmental outcome
- Prenatal exposure to know teratogens
- Positive neonatal toxicology screen or symptomatic neonatal drug withdrawal
- Clinical significant failure to thrive
- Being an infant of a developmentally disabled parent may also be considered a risk factor

- Referrals shall be directed to the intake screener of the Regional Center. Note: When referring to both CCS and RC, one referral shall not delay the other. The PCP may notify CCS and the Regional Center simultaneously if both the medical and early intervention services are necessary. The PCP shall route member information to the RC as soon as possible. Information shall include the following:
  - Reason for referral
  - Complete medical history and physical examination, including appropriate developmental screens
  - The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated

Anyone can make a referral, including parents, medical care providers, neighbors, family members, foster parents, and day care providers.

The PCP is responsible for notifying parents/guardians for the availability of Early Start Services.

The PCP is to cooperate and collaborate in the development of the Individual Program Plan (IPP).

Referral Coordination with California Children Services

In situations where the Member is eligible for both CCS and Early Start, the first or primary referral should be to CCS, if the diagnosis or treatment for the CCS eligible condition is the major concern. The PCP should notify CCS and the appropriate RC simultaneously when both medical and early intervention services are necessary.

Coordination of Care

Depending on plan affiliation, the Medical Case Manager and Medical Director are available to assist PCPs and families with the referral procedure to ensure their referral was completed successfully and services were activated. If a Member was previously referred to or accepted into the Early Start Program, the Medical Case Manager assesses the case to determine if further case management services, including health education, are needed. The Medical Case Manager also contacts the parent/guardian for approval to discuss the member's care with a RC.

Once the referral has been made, the PCP and Medical Case Manager will:
- Provide/refer for medically necessary therapy and/or equipment
- Continue with medical management
- Consult with and provide appropriate reports to the Early Intervention Team
- Assist the client and/or family in following the IFSP recommendation
- MHC will provide transportation to these appointments. Assistance with arrangement for transportation is available through the health plan contracted vendor, Secure Transportation, by calling (855) 740-3166

Consent, Record Keeping, and Confidentiality

The Member or parent/guardian of a minor will consent to any screening, assessment, or treatment. Results of any screening, assessment, or treatment will be recorded in the Member's medical record.

- Documentation will be in compliance with MHC Policy and Procedure, regarding Collection/Use/Confidentiality and Release of Primary Health Care Information
- Findings, recommendations, and response to recommendations will be recorded by the Provider/Practitioner in the Member's medical record
- All information and results of the health assessment of each Member will be confidential and will not be released without the informed consent of the Member or parent/guardian
- Appropriate governmental agencies will have access to records without consent of the Member or responsible adult, i.e., DHCS, DMHC, etc.

DEVELOPMENTAL DISABILITY SERVICE AND REGIONAL CENTER COORDINATION

The Department of Developmental Services (DDS) is responsible for a system of diagnosis, counseling, case management, and community support of persons with intellectual disability, cerebral palsy, epilepsy, autism and related conditions. These services are provided through state-operated developmental centers and community facilities, and contracts with twenty-one (21) nonprofit Regional Centers (RC). The regional centers serve as a local resource to help find and access the services and supports available to individuals with developmental disabilities and their families.

RCs are private, non-profit corporations under contract with the DDS. Their purpose is to enable people with developmental disabilities to lead as independent and productive lives as possible, to protect the legal rights of people with developmental disabilities and their families, and to reduce the incidents of developmental disabilities. Providers/Practitioners must provide eligible Medi-Cal members identified with, or suspected of having, developmental disabilities with all medically necessary and appropriate developmental screenings, primary preventive care, and diagnostic and treatment services. For members at risk of parenting a child with a developmental disability, MHC provides genetic counseling and other prenatal genetic services.

DDS services are for eligible members from thirty-six (36) months to adults. DDS includes Members with a disability that originates before the member attains eighteen (18) years of age, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap for such individual. This may include mental intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to intellectual disability or requiring treatment similar to that required for intellectually disabled individuals, including genetic screening and counseling when indicated. DDS does not include other disabling conditions that are (1) Solely Psychiatric Disorders; (2) Solely Learning Disabilities; and (3) Solely physical in nature.

Eligibility Determination

The Primary Care Physician (PCP) shall provide developmentally disabled Members with all appropriate screening, preventive, Medically Necessary, and therapeutic Covered Services. Preventive care will be provided according to the most recent American Academy of Pediatrics Guidelines for children the Guidelines of United States Preventive Services Task Force for adults and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services. EPSDT benefit provides comprehensive screening, diagnostic, treatment and preventive health care services.
The PCP shall assess and refer eligible Members with developmental disabilities to the Regional Centers for those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement and supportive living.

The MHC PCP shall coordinate all medical services rendered to eligible Members.

The PCP shall complete an intake and assessment for member's age thirty-six (36) months to eighteen (18) years old with, or suspected to have a developmental disability:

- Members shall receive a complete medical evaluation to confirm the diagnosis and determine the genetic and/or non-genetic etiology. This may include, but not be limited to:
  - Prenatal/perinatal history
  - Developmental history
  - Family history
  - Metabolic and chromosomal studies
  - Specialty consultations as indicated

Referral Process

The PCP may refer members who are in need of non-medical, home and community-based services to the RC such as but not limited to:

- Respite
- Out-of-home Placement
- Supported Living & Related Services

Members having, or suspected of having, a developmental disability may be referred to the RC nearest the Member's place of residence. Referrals from the PCP should be directed to the Intake Coordinator at the RC and will include the reason for referral, the complete medical history and physical examination report with appropriate developmental screens, the results of developmental assessment/psychological evaluation, and other diagnostic tests as indicated. California Regional Centers Directory may be accessed at: http://www.dds.ca.gov/rc/RCList.cfm

When MHC and the Medical Director determine that a Member is potentially eligible for a RC service, the Case Manager will contact the PCP or specialist to determine if the Member and the family have been informed and have approved the referral or have been previously referred or accepted into a RC.

If a Member was previously referred to or accepted into the RC, the Case Manager assesses each individual case to determine if further case management services are needed. If services are not required, MHC contacts the parent/guardian for approval to discuss the Member's case with the RC. If the Member was not previously referred to or accepted into the RC, the Case Manager contacts the PCP and the family regarding assistance with the referral process. If requested, the Case Manager assists the family and Provider/Practitioner to complete the referral process.

Intake and Assessment

RC's shall review referrals to determine RC eligibility and consider the need for development programs or family support services which are not available from other generic or private sources

The PCP shall be directed to the RC's intake coordinator and shall provide the following information:

- Reason for referral
- Complete medical history and physical examination, including appropriate developmental screens
- The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated

The RC shall review the referral within fifteen (15) working days of receipt.

Primary Care Practitioner's Responsibilities

PCP shall perform developmental screening including vision and hearing assessments and review of dental status at intervals specified in the CHDP and EPSDT policies and procedures for children up to age eighteen (18).

Medically necessary diagnostic and treatment services for physical and developmental conditions identified in the screenings shall be provided or arranged.

- Primary care and specialized medical treatment necessary shall be provided for:
  - All Medically Necessary and therapeutic Covered Services to Members with developmental disabilities
  - The PCP shall assure evaluation and procurement of the durable and non-durable medical equipment according to UM guidelines

Referral Coordination with California Children Services

In situations where the child is eligible for both California Children Services (CCS) and RC services, the first referral should be to CCS if diagnosis or treatment for CCS eligible conditions is the major concern. The Provider/Practitioner may wish to notify CCS and the appropriate RC simultaneously if both medical and early intervention services are necessary.

Regional Center Responsibilities

The Department of Developmental Services is responsible for designing and coordinating a wide array of services for California residents with developmental disabilities. Regional centers help plan, access, coordinate and monitor these services and supports.

A Person-Centered Planning approach is used in making decisions regarding where a person with developmental disabilities will live and the kinds of services and supports that may be needed. In person-centered planning, everyone who uses regional center services has a planning team that includes the person utilizing the services, family members, regional center staff and anyone else who is asked to be there by the individual. The team joins together to make sure that the services that people are getting are supporting their choices in where they want to live, how and with whom they choose to spend the day and hopes and dreams for the future.

Case Management

- MHC will provide coordination of care and services with primary care practitioners, specialists, and allied health professionals (including speech, occupation and physical therapists), procuring of durable and non-durable medical equipment and securing in-home nursing services and EPSDT supplemental services,
- When needed medical sub-specialty services are not available within the network, the service will be provided out-of-network, with the continuity of care maintained
- With the written consent of the member or parent/guardian of a minor, medical records will be routed to the RC when appropriate
- Case Management will provide follow-up and coordination of the treatment plan between the MHC PCP, any specialists, and the RC

Case Management includes the following:

- For Members thirty-six (36) months to adults, providing or arranging for medically necessary diagnostic and treatment services necessary to correct and/or ameliorate conditions discovered in the screening process

- Providing available medical documentation and reports, as requested, to the RC Case Manager
- Providing or arranging for medically necessary therapies and durable medical equipment

Transportation

MHC will provide transportation to these appointments. Assistance with arrangement for transportation is available through the health plan contracted vendor, Secure Transportation, by calling (855) 740-3166.

Unresolved Questions and Conflicts

RC staff determines eligibility and provides case management services to their clients. Issues that arise between the RC and MHC, or the PCP will be resolved by MHC's Medical Director or the Medical Director of the affiliated health plan. During any problematic periods, a Case Manager and the PCP or specialty practitioner will continue to manage the medical case of the Member. Medical Case Managers will maintain routine interaction with the RC and will share data regarding health care encounters and program enrollment figures. Unresolved questions and conflicts between MHC and RC concerning eligibility, diagnostic testing, treatment plan, and associated Member benefits, should be directed to either of the following:

Molina Healthcare of California Attn: Health Care Services Regional Center Liaison	Manager, DDS Prevention and Children Services Branch Department of Developmental PO Box 944202 Sacramento, CA 94244-2020 (916) 654-1690 or TYY: (916) 654-2054

The MHC Case Manager and Medical Director will coordinate and authorize all immediate health care needs for the Member in collaboration with the PCP until resolution is obtained. Included for your reference is the RCs Information Sheet and Roster.

PCP Monitoring Process

Once eligibility for a RC program is established for a member, the PCP continues to provide Basic Case Management, and all Medically Necessary Covered Services, including Initial Health Assessment (IHA), and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings that are unrelated to the RC eligible condition. The PCP remains responsible for the provision of Basic Case Management and all medically necessary diagnostic, preventive and specialty referrals for treatment services, including Initial Health Assessment (IHA), and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings. Molina audits PCP compliance with these requirements through regularly requesting attestations of compliance, and by performing monthly PCP file audits.

CALIFORNIA DEPARTMENT OF DEVELOPMENTAL SERVICES

Regional Centers

The Department of Developmental Services (DDS) is responsible for coordinating a wide array of services for California residents with developmental disabilities, infants at high-risk for developmental disabilities, and individuals at high risk for parenting a child with a disability. These services are, provided through a statewide system of twenty (20) locally based RCs.

The DDS contracts with the RCs to offer services in all fifty-eight (58) California counties. Located throughout the State, the local RCs serve as the point of entry into the developmental mental disabilities service system

including admissions to the developmental centers. The RCs provide intake and assessment services to determine client eligibility and service needs. RCs then work with other agencies and utilize "generic services" whenever possible to arrange purchase and provide services including the full range of early intervention services. Early intervention services that cannot be provided by other publicly funded agencies are generally purchased through contracts with service Providers/Practitioners that are "vendor" by a RC. Services vary among the RCs based on local needs and resources.

REGIONAL CENTERS	DIRECTOR	AREAS SERVED
Alta California 2241 Harvard St., Ste. 100 Sacramento, CA 95815	**Phil Bonnet** (916) 978-6400	Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba counties
Central Valley 4615 North Marty Ave. Fresno, CA 93722	**Heather Flores** (559) 276-4300	Fresno, Kings, Madera, Mariposa, Merced, and Tulare counties
Eastern Los Angeles 1000 South Fremont Alhambra, CA 91802 **Mailing Address:** P.O. Box 7916 Alhambra, CA 91802	**Gloria Wong** (626) 299-4700	Eastern Los Angeles county including the communities of Alhambra and Whittier
Far Northern 1900 Churn Creek Rd., #319 Redding, CA 96002	**Laura Larson** (530) 222-4791	Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama, and Trinity counties
Frank D. Lanterman 3303 Wilshire Blvd., Ste. 700 Los Angeles, CA 90010	**Melinda Sullivan** (213) 383-1300	Central Los Angeles county including Burbank, Glendale, and Pasadena
Golden Gate 1355 Market Street, Suite 220 San Francisco, CA 94103	**Eric Zigman** (415) 546-9222	Marin, San Francisco, and San Mateo counties
Harbor 21231 Hawthorne Blvd. Torrance, CA 90503	**Patricia Del Monico** (310) 540-1711	Southern Los Angeles county including Bellflower, Harbor, Long Beach, and Torrance
Inland 1365 S. Waterman Ave. San Bernardino, CA 92408 **Mailing Address:** P. O. Box 19037 San Bernardino, CA 92423	**Lavina Johnson** (909) 890-3000	Riverside and San Bernardino counties
Kern 3200 North Sillect Ave. Bakersfield, CA 93308	**Michi Gates** (661) 327-8531	Inyo, Kern, and Mono counties
North Bay 610 Airpark Road Napa, CA 94558	**Gabriel Rogin** (707) 256-1100	Napa, Solano, and Sonoma counties
North LA County 9200 Oakdale Ave, Ste 100 Chatswprtj, CA 91311	**George Stevens** (818) 778-1900	Northern Los Angeles county including San Fernando and Antelope Valleys

REGIONAL CENTERS	DIRECTOR	AREAS SERVED
Redwood Coast 1116 Airport Park Blvd, Ukiah, CA 95482	**Rick Blumberg, Ph.D.** (707) 462-3832	Del Norte, Humboldt, Mendocino, and Lake counties
San Andreas 6203 San Ignacio Ave, Ste.200 San Jose, CA 95119	**Javier Zaldivar** (408) 374-9960	Monterey, San Benito, Santa Clara, and Santa Cruz counties
San Diego 4355 Ruffin Rd., Ste. 200 San Diego, CA 92123	**Carlos Flores** (858) 576-2996	Imperial and San Diego counties
San Gabriel/Pomona 75 Rancho Camino Drive Pomona, CA 91768	**R. Keith Penman** (909) 620-7722	Eastern Los Angeles county including El Monte, Monrovia, Pomona, and Glendora
South Central LA 2500 S. Western Ave. Los Angeles, CA 90007	**Dexter Henderson** (213) 744-7000	Southern Los Angeles county including the communities of Compton and Gardena
Tri-Counties 520 East Montecito St. Santa Barbara, CA 93103	**Omar Noorzad, Ph.D.** (805) 962-7881	San Luis Obispo, Santa Barbara, and Ventura counties
Valley Mountain 702 North Aurora St. Stockton, CA 95202 **Mailing Address:** PO Box 692290 Stockton, CA 95269-2290	**Tony Anderson** (209) 473-0951	Amador, Calaveras, San Joaquin, Stanislaus, and Tuolumne counties
Westside 5901 Green Valley Cir., Ste. 320 Culver City, CA 90230-6953	**Carmine Manicone** (310) 258-4000	Western Los Angeles county including the communities of Culver City, Inglewood, and Santa Monica

8.4 HEALTHCARE SERVICES: WAIVER PROGRAMS

DEVELOPMENTAL DISABILITIES SERVICES WAIVER

The Developmental Disabilities Services (DDS) administered Home and Community Based Services (HCBS) waiver program was established to meet the medical needs of developmentally disabled Medi-Cal recipients age thirty-six (36) months to adults. DDS includes members with a disability that originates before the Member attains eighteen (18) years of age, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap for such individual. DDS and MHC coordinate the medical management of chronically ill, developmentally disabled Medi-Cal Members, including those with catastrophic illnesses, technologically dependent and/or risk of life-threatening incidences, who, but for the provision of such services, would reside in an intermediate care facility for the developmentally disabled.

DDS HCBS Waiver Program

Regional Centers (RCs) oversee the DDS administered HCBS waiver program. There are four (4) types of care settings in the HCBS waiver program:

- Member's home where specialized services may be delivered
- Local intermediate care facility licensed as an ICS/DD
- Local habilitative developmental-disability care facility licensed as a DDH
- Local nursing developmental-care facility licensed as a DDN

The RC Inter-Disciplinary Team is responsible for determining the HCBS waiver setting most appropriate for the eligible Member. Although the RCs provide overall case management, they are not responsible for the direct medical services. During the Member's participation in the DDS administered waiver program, MHC will continue to provide all primary care and other medically necessary services.

Eligibility

MHC Case Management staff will monitor and review inpatient stays of members with a potential need for supportive care, to determine appropriate utilization and to identify Members who may potentially benefit from a DDS HCBS waiver. Case Managers will also work to ensure that potentially eligible Members are referred in a timely manner. Included for your reference is the DHCS assigned waiver criteria.

Referrals to HCBS

When a Case Manager is notified of a Member with a potential need for supportive care, the Case Manager will initiate a request for the medical record from the Member's Primary Care Practitioner (PCP). Upon receipt of the Member's medical records, the Case Manager and the Medical Director will review the records to determine if there is a need for supportive care. If supportive care is not needed, no referral is made and the Member or family is notified.

If supportive care is deemed necessary, a case conference will be conducted with the Member and/or family, PCP, specialist, ancillary Providers/Practitioners, and MHC Case Manager. The MHC Case Manager is responsible for coordinating with the RC Case Manager and the PCP.

Referral and Coordination of Services

Once a Member is deemed eligible for the DDS administered HCBS program, a RC Case Manager is assigned to coordinate waiver services. The receiving of DDS administered HCBS services does not warrant or require a Member's disenrollment from the Plan.

PCP's Responsibilities

The PCP's primary responsibility is to refer Members, transmit medical records, and develop a plan of treatment. The PCP, along with the Case Manager as necessary, is still required to provide and coordinate care.

The Case Manager is responsible for coordinating with the RC Case Manager and the PCP in the development of the Member's individual services plan/individual education plan.

If the Member is receiving services through DDS, the Case Manager assists in coordinating care with the PCP and RC. If the Member is not receiving services through DDS, the Case Manager conducts an analysis of the cost-effectiveness of in-home services versus institutional services:

- If the member's condition meet criteria for the waiver program, the Case Manager makes an appropriate referral to DDS at:
  Department of Developmental Services
  Department of Health Care Services
  1600 9th Street
  P.O. Box 944202
  Sacramento, CA 94244-2020
  (916) 654-1690
- If the member does not meet the criteria for the waiver program, or if placement is not available, MHC will continue to case manage and provide all medically necessary services to the member

Problem Resolution

RC's staff determines eligibility and is responsible for the overall case management of the member. In the event that MHC is in disagreement with the RC's decision and/or recommendation concerning the provision of waiver services, the Case Manager will be responsible for problem resolution. The Case Manager will continue to coordinate and authorize all immediate health care needs for the member in collaboration with the PCP until resolution is reached.

WAIVER PROGRAMS - DEVELOPMENTAL DISABILITIES

DDS HCBS Waiver Participants

Administered by the Department of Developmental Services

- A recipient may only receive waiver services from the DDS HCBS
- A recipient may receive Medi-Cal benefits if "medically necessary"
- A recipient may receive Supplemental EPSDT benefits
- A recipient of waiver services must meet the criteria for participation in the waiver program AND meet the criteria for medical necessity
- The determinations of eligibility for participation in the DDS HCBS waiver are made by the RC
- The determinations of necessity of services are made by the RC Interdisciplinary Team using their person-centered planning process
- If the member has a qualifying condition or diagnosis under the Developmental Disabilities Program for the Waiver Programs and the Member is over age twenty-one (21), the MHC Case Management Department will evaluate eligibility for other programs

- Children with diagnosis of developmental delay are not eligible for the DDS HCBS waiver
- Children at risk of developing a developmental disability are not eligible for the DDS HCBS waiver
- The Member must be a consumer of the RC and the RC will be contacted to provide oversight
- The Member must meet the admission requirements for an ICF/DD, ICF/DD-H, or ICF/DD-N facility and require some medical care and active treatment
- The Member must be a Medi-Cal beneficiary

Institutional DDS HCBS Waiver Participants

- The Member must meet all criteria for DDS HCBS waiver program
- The Member must have been determined eligible for DDS HCBS waiver services
- The Member must receive a referral from the RC to the County for Medi-Cal fiscal eligibility determination using institutional rules
- The Member must receive at least one (1) DDS HCBS waiver service at all times in order to maintain Medi-Cal eligibility

AIDS WAIVER PROGRAM

The AIDS Waiver Program is designated to provide in-home care to recipients who would otherwise require institutionalization in a medical facility for a prolonged period.

Eligibility

To qualify for enrollment in the AIDS Waiver Program, members with Acquired Immune Deficiency Syndrome (AIDS) or symptomatic Human Immunodeficiency Virus (HIV) disease must meet the following criteria:

- Be Medi-Cal eligible
- Require nursing facility (NF) level of care or above
- Score sixty (60) or less on the Kamofsky Scale
- Have exhausted other coverage for health care benefits similar to those available under the AIDS waiver prior to utilization of AIDS waiver services
- Have a safe home setting

For children, waiver agencies must choose the Centers for Disease Control and Prevention "Classification System for Human Immunodeficiency Virus Infection in Children under 13 Years of Age." Children must be classified as "P2" under the CVC classification to be eligible for the waiver program.

The PCP, with assistance from the Case Management staff, as requested, will inform eligible members about the availability of the AIDS Waiver Program. At the request of a member, the PCP will provide the Waiver Agency with appropriate medical documentation including:

- History and physical
- Relevant lab results
- Therapeutic regime

Information and documentation will be submitted for acceptance to:

Office of AIDS, California Department of Public Health (CDPH)
MS7700
P.O. Box 997426
Sacramento, CA 95899-7426

(916) 449-5900
(916) 449-5909

Case Management and Coordination Process

Once MHC Case Management Staff is notified of a Member with a potential need for supportive care, staff requests medical records from the Member's PCP. Case Management Staff, with the PCP, meets with the Member and caregivers to discuss AIDS Waiver Program availability:

- If the Member is eligible for and requests program referral, the type of supportive care needed is identified and a referral is initiated by the Case Manager
- If the Member is determined to be ineligible or declines program referral, the Case Manager initiates case management as necessary

The Case Manager coordinates the transfer of the case management plan and/or any pertinent information to the AIDS Waiver Program representative. Financial limitations of the program are provided on a yearly basis per patient per calendar year. The carve-out of AIDS medications is included for your reference.

Problem Resolution

Resolution of problems or conflicts between the HIV/AIDS provider/practitioner and Office of AIDS can be addressed to either of the following:

Molina Healthcare of California
Attn: Chief Medical Officer
200 Oceangate, Suite 100
Long Beach, CA 90802
(800) 526-8196

Office of AIDS
California Department of Public Health
MS7700
P.O. Box 997426
Sacramento, CA 95899-7426
(916) 449-5900
(916) 449-5909 (fax)

HOME AND COMMUNITY-BASED SERVICES

The Home and Community Based Services (HCBS) are designated to provide in-home care to recipients who would otherwise require institutionalization in a medical facility for a prolonged period.

The medical management of chronically ill Members, including Members with catastrophic illnesses, technologically dependent and/or risk of life-threatening incidences; require close coordination between MHC, its subcontracted Providers/Practitioners, and the In-Home Operations (IHO) administered HCBS waiver program. The primary goal is to ensure that the medical needs of Members who are physically, and possibly mentally, disabled are met appropriately and safely in a home environment.

- In-Home Medical Care (IHMC) Waiver - The IHMC Waiver is designed for Medi-Cal recipients who, in the absence of the waiver, would be expected to require at least ninety (90) days of acute hospital care before beginning IHMC Waiver services
- Skilled Nursing Facility (SNF) - The SNF Waiver is designed for persons who are physically disabled or aged at the NF Level B SNF level of care and who are inpatients of an NF Level B, or whose admission to an NF Level B is imminent

Referral and Coordination Process

MHC staff will monitor and review all in-patient stays to determine appropriate utilization and to identify Members who may potentially benefit from an HCBS waiver. The MHC staff will review the potentially eligible Member's medical needs and prognosis for ongoing care with the PCP and Inpatient Facility Discharge Planner/Case Manager.

The PCP will inform the Member, guardian, or authorized representative about the availability of in-home care alternatives. Such education will be documented in the Member's medical record. On consent of the Member, guardian, or authorized representative, the MHC staff will coordinate with the Inpatient Facility Discharge Planner/Case Manager to refer the Member to a licensed and Medi-Cal certified Home Health Agency for evaluation.

The Home Health Agency Multi-Disciplinary Team will evaluate the Member's health care needs and the appropriateness of the Member's home and health environment. In coordination with the hospital staff, MHC's Case Manager will request an interdisciplinary care team conference. Attendees will include the Member and/or family caregivers, PCP and/or attending Provider/Practitioner, Inpatient Facility Discharge Planner, Case Manager, and the Home Health Agency Case Manager. The purpose of this conference is to assess the feasibility of in-home care, to recommend the appropriate services necessary to meet the health care needs of the Member and to predict a potential start date for in-home care.

Authorization

The Home Health Agency will prepare all necessary Letters of Agreement and the Treatment Authorization Request (TAR). Home Health Agencies are encouraged to identify the waiver recipient by highlighting "waiver recipient" in the Provider/Practitioner address section of the TAR. The Home Health Agency will submit the appropriate information to the following:

For programs administered by In-Home Operations, including Nursing Facilities Waiver and In-Home Medi-Cal Waiver, appropriate information should be submitted to:

Senior and Adult In-Home Supportive Services
4875 Broadway Sacramento, CA 95820
Telephone: (916) 874-9471
Fax: (916) 874-9682

If the agency administering the waiver program concurs with MHC's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while still being enrolled with MHC. MHC shall continue to provide all medically necessary covered services to the Member.

Problem Resolution

In the event of a disagreement with the Authorizing Unit decision and/or recommendations concerning the provision of waiver services, MHC's Case Manager will be responsible for initiating the problem resolution process.

The Authorizing Unit Staff determines eligibility and the Home Health Agency Case Manager is responsible for the overall case management of the Member. If prior to disenrollment from MHC, a participating Provider/Practitioner disagrees with an Authorizing Unit's decision regarding eligibility or the Home Health Agency's Case Manager's service provisions, all medical records and correspondences will be forwarded to the MHC Medical Director at:

Molina Healthcare of California

Attn: Medical Director
200 Oceangate, Suite 100
Long Beach, CA 90802
Telephone: (800) 526-8196
Fax: (562) 499-6173

The MHC Case Management Department will continue to coordinate with the MHC Medical Director to authorize all immediate health care needs for the Member in collaboration with the PCP until resolution is obtained. The Authorizing Unit Staff will forward issues to MHC's Medical Director for resolution at the County and State level.

NURSING FACILITY WAIVER PROGRAM

Criteria for Nursing Facility (NF) Waiver Program

Administered by In-Home Operations

- The beneficiary for whom in-home medical care waiver services are requested would otherwise require care in an inpatient acute care hospital for at least ninety (90) consecutive days
- The total cost incurred by the Medi-Cal program in providing in-home medical care waiver services and other medically necessary Medi-Cal services to the beneficiary is less than the total cost incurred by the Medi-Cal program in providing all medically necessary services to the beneficiary in an inpatient acute care hospital
- Case Management services that are provided by a licensed Registered Nurse (RN) consist of ongoing inpatient assessment, evaluation, routine case recording, and preparation of reports to PCP and Medi- Cal regional offices
- Nursing care is provided by a certified individual supervised by an RN or Licensed Vocational Nurse (LVN)
- Those physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the individual or to enable the recipient to function with greater independence in the home and without which the recipient would require institutionalization. The service is a one (1) time event as required by the recipient's plan of care
- Care consists of duties identified by the Board of Registered Nursing to be performed by RNs only, as defined in Title 22, C.C.R., Section 51067
- Care provided by a licensed individual as defined under Title 22, C.C.R., Section 51069
- A Personal Emergency Response System (PERS) is an electronic device which enables individuals at high-risk of institutionalization to secure help in the event of an emergency
- Family training is provided by a licensed RN for the families of individuals served under this waiver. Training includes instruction about treatment regimens and use of equipment specified in the plan of care and will include updates as necessary to safely maintain the individual at home
- Physical Therapy services will include evaluation, treatment planning, treatment, instruction, consultation services, and treatment of any bodily condition by the use of physical, chemical, and other properties of heat, light, water, electricity or sound, and by massage and active, resistive, or passive exercise. Single procedure to one (1) resistive or passive exercise. Single procedure to one (1) area - initial thirty (30) minutes
- Occupational Therapy - services prescribed by a Provider/Practitioner to restore or improve a person's ability to undertake activities of daily living when those skills are impaired by developmental or psychosocial disabilities, physical illness, or advanced age. Occupational Therapy services will include evaluation, treatment planning, instruction, and consultation services. Treatment - initial thirty (30) minutes with additional treatment of fifteen (15) minutes each

- Speech Therapy services - speech language therapy per one-half (1/2) hour
- Audiology services are services for the purpose of identification, measurement, appraisal, and counseling related to hearing and disorders of hearing, the modification of communicative disorders resulting from hearing loss affecting speech, language and audio logical behavior, and the recommendation and evaluation of hearing aids. Hearing Therapy per one-half (1/2) hour
- Family Therapy is a service in which appropriate assessments are made by a qualified counselor to the recipient, as well as group and family counseling with the recipient, with regard to the psychological adjustment to home and community-based care. One (1) and one-half (1/2) hours maximum
- Utility services directly attributable to the operation of life-sustaining medical equipment in the recipient's place of residence to prevent re-institutionalization of waiver recipients who are dependent upon medical technology for survival in or out of an institution. Utility coverage must be included in the plan of care
- Shared nursing services provided to two (2) or more recipients by a licensed RN, in accordance with the plan of care
- Shared nursing services to two (2) or more recipients by a licensed LVN under the direction of an RN, in accordance with the plan of care
- Shared nursing services provided to two (2) or more recipients by a licensed Home Health Aide under the direction of an RN in accordance with the plan of care
- Unspecified waiver services to be used for unlisted NF waiver services
- Members do not need to disenroll from MHC while they are enrolled in the Nursing Facility/Acute Hospital Waiver (NF/AH Waiver) Program

Criteria for Pediatric Sub-Acute

- Tracheostomy care with continuous mechanical ventilation for a minimum of six (6) hours each day
- Tracheostomy care with suctioning and room air or oxygen as needed and one (1) of the six (6) treatment procedures listed below
- Administration of any three (3) of the six (6) treatment procedures listed below

Treatment Procedures

- Total parenteral nutrition
- Inpatient physical, occupational, and/or speech therapy, at least two (2) hours per day, five (5) days per week
- Tube feeding (nasogastric or gastrostomy)
- Inhalation therapy treatments every shift at a minimum of four (4) times per twenty-four (24) hour period.
- IV therapy involving:
- The continuous administration of a therapeutic agent
    - The need for hydration
    - Frequent intermittent IV drug administration via a peripheral and/or central line
- Dependence on peritoneal dialysis treatments requiring at least four (4) exchanges every twenty-four (24) hours

ADULT SUB-ACUTE

Criteria are based on: Milliman and Robertson: Alternative Setting Criteria.
IN-HOME MEDICAL WAIVER

Criteria for In-Home Medical Waiver

Administered by the In-Home Operations

- The attending Provider/Practitioner and Medical Director or designee has determined that the patient requires the acute level of care
- The attending Provider/Practitioner takes total responsibility for the care of the patient
- The patient's condition is chronic and requires long-term care. The patient is relatively stabilized so as to make in-home care safe and feasible
- The home setting is medically appropriate as determined by the Medical Director or designee
- A supportive home and/or community environment makes home placement possible
- The cost of home and community-based care is less than the cost of acute care for the individual and is the least costly care available and is appropriate for the individual

8.5 HEALTHCARE SERVICES: LONG TERM SERVICES & SUPPORTS

Molina Medi-Cal Members have access to a variety of Long-Term Services and Supports (LTSS) to help them meet daily needs for assistance and improve quality of life. LTSS benefits are provided over an extended period, mainly in Member homes and communities, but also in facility-based settings such as nursing facilities as specified in his/her Individualized Care Plan. Overall, Molina's care team model promotes improved utilization of home and community-based services to avoid hospitalization and nursing facility care. Molina case managers will work closely with LTSS centers and staff to expedite evaluation and access to services.

LTSS includes all of the following:

- Community Based Adult Services (CBAS)
- In Home Supportive Services (IHSS)
- Multipurpose Senior Services Program (MSSP)
- Long Term Care, Custodial Level of Care in a Nursing Facility

Under the California Coordinated Care Initiative (CCI) which began in April 2014 for Riverside, San Bernardino and San Diego counties and in July 2014 for Los Angeles county, beneficiaries who wish to receive these services must get them through a Medi-Cal Managed Care Plan. Molina Members in Sacramento and Imperial counties will also get CBAS through Molina but the other LTSS options remain as waiver programs. Under California policy Molina provides coordination between medical care, LTSS, and mental health and substance use benefits covered by Medicare and Medi-Cal. Much of this coordination requires stronger partnership between Molina and county agencies that provide certain LTSS benefits and services. The MOU between Molina and county agencies delineates roles and responsibilities, and processes for referrals and will serve as the foundation for such coordination efforts.

MULTIPURPOSE SENIOR SERVICES PROGRAM

Multipurpose Senior Services Program (MSSP) provides social and health care management for frail elders who are eligible for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care.

MSSP assists frail, elderly members, sixty-five (65) years and over and at-risk of nursing home placement, to remain safely in their homes. MHC members may be eligible for MSSP if they are sixty-five (65) years of age or older, live within an MSSP sites service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP site staff makes this certification determination based upon Medi-Cal criteria for placement.

MSSP services include:

- Adult day care
- Housing assistance
- Chore and personal care assistance
- Protective supervision
- Care management
- Respite
- Transportation
- Meal services

- Social services
- Communications services

Referral and Coordination Process

MHC Case Management staff monitors and reviews members to determine appropriate utilization of services and to identify Members who may potentially benefit from the MSSP program.

Providers needing to make a referral should call our Case Management department at
FAX: (562) 499-6105 PHONE: (800) 526-8196 ext. 127604 or
MHCCaseManagement@MolinaHealthcare.com and request assistance in referring the Member for MSSP and other community resources.

The health plan's Case Management staff will make referrals as appropriate and work along with the PCP to work with the MSSP Waiver Case Management Team to coordinate appropriate services.

Case Management Process

If the Member is determined to be eligible for program referral to the MSSP, MHC or affiliated subcontracted plan Case Manager shall actively participate in the MSSP Case Management Team to develop a comprehensive case management plan. The Case Manager will assist the MSSP team to ensure timely, effective, and efficiently coordinated services to meet the Member's care plan goals.

Problems and Resolutions

In the event that there is a disagreement with the MSSP decision and/or recommendations concerning the provision of waiver services, please refer to the State APL 15-002 Multipurpose Senior Services Program Complaint, Grievance, Appeal, and State Hearing Responsibilities in Coordinated Care Initiative Counties.

COMMUNITY BASED ADULT SERVICES (CBAS)

Licensed Community Based Adult Services (CBAS) Centers provide health and social services as an alternative to institutionalization and a safe and therapeutic environment for adult MHC Members with eligible conditions.

As of October 1, 2012, MHC became financially responsible for all CBAS services; however, the Primary Care Practitioner (PCP) continues to be responsible for providing medically necessary care. CBAS includes nursing and therapeutic care for the Member who may have a physical or mental impairment that handicaps daily activities but who does not require institutionalization.

Eligibility

To be eligible to receive CBAS services, one of the following criteria's must be met:
- Nursing facility level A eligible
- Chronic acquired or traumatic brain injury or chronic mental health
- Alzheimer's disease or other dementia stage 5, 6, 7
- Mild cognitive impairment, including stage 4 dementia
- Developmental disability
- A physician, nurse practitioner or other health care provider has within his/her scope of practice requested ADHC services

- Member must need supervision with two or more of the following activities of daily living: bathing, dressing, self-feeding, toileting, ambulation, transferring, money management, accessing resources, meal preparation or transportation.

Referral

- Complete & fax CBAS Request for Services Form at: (800) 811-4804
- For more information or if you have any questions, please call MHC Utilization Management Department at: (800) 526-8196 or Member Services Department at (888) 665-4621

IN-HOME SUPPORTIVE SERVICES

In-Home Supportive Services (IHSS) is a California program that provides in-home care for Members who cannot safely remain in their own homes without assistance. To qualify for IHSS, Members must be over sixty-five (65) years of age, or disabled, or blind By providing in-home assistance to low income aged and disabled individuals, the IHSS program prevents premature nursing home or board and care placement and allows people to remain safely in their own homes and communities.

IHSS is covered under the Medi-Cal benefit. Molina Healthcare of California coordinates IHSS benefits for eligible enrollees through county IHSS agencies. IHSS consumers' self-direct their care by hiring, firing, and managing their IHSS workers. County social services agencies conduct the IHSS assessment and authorization processes, including determining IHSS hours. The current fair hearing process for IHSS remains the same.

Services included in IHSS include:

- Housecleaning
- Meal preparation and clean-up
- Laundry
- Grocery shopping and errands
- Personal care services (bowel/bladder care, bathing, paramedical service, etc.)
- Accompaniment to medical appointments
- Protective supervision for persons with cognitive or intellectual disabilities

One of the most noteworthy aspects of the IHSS program is the beneficiaries' ability to self-direct their care. Self-directed care is the process by which the IHSS consumer who is disabled, blind or over the age of sixty-five (65), and who meets the eligibility criteria for IHSS, chooses to hire, train, supervise, and if necessary fire the personal assistant. In situations where the member is unable to self-direct their care, Molina case managers will coordinate with county social workers.

How to refer Molina Members in need of IHSS Services:

Providers needing to make a referral should call Member Services at (888) 665-4621 or the Case Management department at (800) 526-8196 ext. 127604 or email MHCCaseManagement@MolinaHealthcare.com and request assistance in referring the member for IHSS and other community resources.

Members can also call or visit their local County Social Services agency to verify eligibility and begin the application process. The **Health Certification Form** will be sent to the member by the county social worker. It is important to note that the application process cannot continue until the physician has completed it.

- **Sacramento County** (Dept. of Human Assistance): (916) 874-9471
- **San Diego County** (Dept. of Health & Human Services): (800) 339 -4661
- **Riverside County** (Dept. of Public Social Services): (999) 960-4477

- **San Bernardino County** (Dept. of Human Services): (877) 800-4544
- **Los Angeles County** (Dept. of Public Social Services): (888) 944-4477
- **Imperial County** (Dept. of Social Services) : (760) 337-6829

LONG-TERM CARE

MHC will ensure that eligible Members, other than Members requesting hospice, in need of nursing facility services are placed in facilities providing the appropriate level of care commensurate with the Member's medical needs.

Eligibility and Referral

When a referral to a long-term care facility is initiated by an in-patient attending physician, the MHC Medical Director will be notified by MHC Utilization Management Department. The hospital Discharge Planner will notify the MHC PCP of such referral.

Referral to the appropriate long-term care facility should be made when the Provider/Practitioner has determined that the Member meets, or may meet, the criteria for any of the following long-term care facilities:

- Transitional care
- Intermediate care facility
- Sub-acute care facility
- Rehabilitative care facility
- Pediatrics sub-acute care facility
- Skilled nursing facility (SNF)
- Short-term care
- Long-term care
- Custodial care

Potentially appropriate Members for long-term care referral are identified by MHC's or affiliated health plan's Utilization Management Nurse Reviewers during the admission and concurrent review process.

Other sources of identification include, but are not limited to, case managers, specialty care Providers/Practitioners, social workers, discharge planners, and any other health care Providers/ Practitioners involved in the Member's care.

Long-term care guidelines for determining the appropriate level of care are based on the MC/FFS guidelines.

Authorization

The PCP will perform an assessment of the Member's needs to determine appropriate level of service prior to the request for an admission to a long-term care facility. The PCP will obtain an authorization for admission to a long-term care facility from MHC's Utilization Management Department. The Utilization Management Department will direct the admission to a contracted long-term care facility. If a contracted facility is unavailable to meet the Member's needs, the Member will be placed at an appropriate facility on a case-by-case basis. The frequency of review by the UM Medical Director will be based on the Member's acuity and clinical condition.

If the Member does not meet the criteria for custodial level of care or an admission to a long-term care facility, the Molina will continue to provide case management services until the treatment is completed.

For custodial authorization or outpatient services needed while in custodial level of care, please fax all requests to the prior authorization department: at 800-811-4804.

For any questions regarding custodial authorization or services needed while in custodial level of care, please contact the MHC UM Prior Authorization Department at (844) 557-8434.

Hospice Care

Hospice services are a covered benefit regardless of the expected or actual length of stay in a nursing home. Members with terminal illnesses (a life expectancy of less than six (6) months) are candidates for hospice services. The determination of medical appropriateness for hospice is performed by the PCP or the Provider/Practitioner in charge of the member's care.

Once the determination for hospice is deemed appropriate, the PCP will obtain an authorization from the CAM Department. The Utilization Management Nurse Reviewer will monitor the case and ensure coordination of all necessary services.

8.6 HEALTHCARE SERVICES: ALCOHOL & SUBSTANCE USE DISORDERS TREATMENT & SERVICES

ALCOHOL AND DRUG TREATMENT SERVICES

Drug Medi-Cal (D/MC), also referred to as Short-Doyle Medi-Cal (SD/MC), alcohol and drug treatment services are excluded from MHC's Medi-Cal Drug and Alcohol coverage responsibility under the Two-Plan Model Contract. Services are available under the SD/MC programs and through Heroin Detoxification Treatment Services. These services are provided through county operated SD/MC programs, or through direct contracting between the State Department of Alcohol and Drug Programs and community-based Providers/Practitioners.

MHC and subcontracted Providers/Practitioners coordinate referrals for Members requiring specialty and inpatient clinical dependency/substance abuse treatment and services. Members receiving services under the SD/MC Program remain enrolled in MHC. Contracted PCPs are responsible for maintaining continuity of care for the Member.

Alcohol Misuse Screening and Counseling (AMSC)

Effective January 1, 2014, California offers an Alcohol Misuse Screening and Counseling benefit to adult Medi-Cal beneficiaries. The AMSC benefit is offered to all Medi-Cal beneficiaries, eighteen (18) years and older, in primary care settings. This benefit requests that clinicians screen adults for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services, as medically necessary.

All providers that will be providing AMSC services may complete a minimum of four (4) hours of AMSC training. The training is not required; however, it is recommended. This applies to licensed providers such as primary care physicians, physician assistants, nurse practitioners, and psychologists who are supervising non-health care providers who are rendering AMSC services. This training recommended also applies to trained, unlicensed providers such as health educators, health coaches, and certified addiction counselors.

- Screening: As part of routine care, Members must be asked the alcohol question on the Individual Health Education Behavioral Assessment (IHEBA).This is considered a pre-screen. If a Member answers "yes" to the alcohol screening question, the PCP must offer the Member an expanded, validated alcohol screening questionnaire such as the Alcohol Use Disorder Identification Test (AUDIT) or the Alcohol Use Disorder Identification Test—Consumption (AUDIT-C). Documentation of the IHEBA and expanded screening must be maintained in medical records
- Brief Intervention: Providers must offer brief intervention(s) to Members that are identified as having risky or hazardous alcohol use when a Member responds affirmatively to the alcohol question in the IHEBA. Brief intervention(s) typically include one to three (1-3) sessions, fifteen (15) minutes in duration per session, offered in-person, by telephone, or by tele health modalities. Members are allowed at least three (3) brief intervention sessions per year
- Referral to Treatment: Members who are found to meet criteria for an alcohol use disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), or whose diagnosis is uncertain, should be referred for further evaluation and treatment to county Alcohol and Drug Services or DHCS-certified treatment program. For further diagnostic evaluation and treatment, please refer to the alcohol and drug program of the county in which the Member resides

If you have any questions or require further clarification regarding AMSC services or training requirements, please contact your regional Provider Services Representatives.

Alcohol and Drug Treatment Services

The alcohol and drug treatment services covered by the SD/MC programs include, but are not limited to:

- Outpatient methadone maintenance services
- Outpatient drug-free treatment services
- Daycare habilitative services
- Perinatal residential substance abuse services
- Naltrexone treatment services for opiate addiction

Members receiving alcohol and drug treatment services through the SD/MC program remain enrolled in MHC.

Referral Documentation

PCPs are responsible for performing all preliminary testing and procedures necessary to determine an appropriate diagnosis. Referrals to SD/MC and/or Fee-For-Service Medi-Cal (FFS/MC) Program should include the appropriate medical records supporting the diagnosis and the required demographic information. After eligibility is approved by the County FFS/MC and/or SD/MC Program, the Member's PCP will submit the requested medical record to assist in the development of a comprehensive treatment plan. A final decision on acceptance of a Member for FFS/MC and/or SD/MC services rests solely with the County Alcohol and Drug Program.

Criteria for Referral for Alcohol and/or Drug Treatment Services

The need for alcohol and/or drug treatment services is determined by the PCP on the basis of objective and subjective evaluation of the Member's medical history, psychosocial history, current state of health, and any request for such services from either the Member or the Member's family. Various screening tools are included in this Manual to assist the PCP in the detection of substance abuse.

Referral Process

- The need for alcohol and/or drug treatment services is determined by the PCP on the basis of objective and subjective evaluation of the Member's medical history, psychosocial history, current state of health, and request for such services from either the Member or the Member's family
- Once the determination has been made to refer the Member for alcohol and drug treatment services to a Short-Doyle (SD) Provider/Practitioner or a Fee-For-Service (FFS) Provider/Practitioner, the PCP may make the referral directly or may refer the Member to MHC or its affiliated health plan Medical Case Manager for the coordination of services and follow-up
- According to local preference, referrals are made to a central intake center or directly to a SD/FFS Provider/Practitioner. In both cases, the County Office of Alcohol and Drug Programs will conduct an authorization and review process to determine the appropriate level of care for the Member. The County Office of Alcohol and Drug Programs has determined specific criteria for appropriateness and need for services, including medical or service necessity, focus of care and frequency of service
- When appropriate, the health plan Medical Case Manager coordinates with the MHC Member Services Department and/or Health Education Department to meet a member's cultural and linguistic needs

- Providers/Practitioners seeking guidance in the provision of services to Members with specific cultural needs are referred to the Health Education Department and the department will offer assistance
- Daycare Habilitative Services are reimbursable only if they are provided for pregnant or postpartum members and for Early and Periodic Screening, Diagnosis and Treatment-eligible Medi-Cal Members
- SD/MC services within the five (5) treatment modalities referenced may be provided to a Member and billed to the SD/MC program. No other additional treatment services may be authorized and paid within the SD/MC payment system

PCP's Responsibilities

- PCPs are responsible to act as the primary care practitioner for the Member and to make referrals to medical specialists, as necessary
- The PCP is responsible for performing all preliminary testing and procedures necessary to determine diagnosis. Should the Member require specialty service, the PCP will refer the Member to the appropriate SD/MC alcohol and drug Provider/Practitioner
- The PCP will make available all necessary medical records and documentation relating to the diagnosis and care of the mental health condition prompting the referral
- The PCP will assure that appropriate documentation is in the Member's medical record
- The PCP will screen and thoroughly assess the Member for additional conditions that may directly or indirectly impact the treatment or care of the Member
- PCPs are responsible for coordinating care and services for non-SD/MC related conditions, which may include problems and unmet health care needs directly and indirectly related to or affected by the Member's addiction and lifestyle. This assessment may include medical conditions such as Acquired Immune Deficiency Syndrome (AIDS)/HIV, cirrhosis, tuberculosis, abscesses, sexually transmitted diseases, infections, lack of necessary immunizations, and/or poor nutrition. This assessment may also include psychiatric disorders such as depression, bipolar disorder, and other anti-social personality disorders that contribute to repeating the cycle of addiction and substance abuse

Criteria for Inpatient Detoxification

A Member will be considered a candidate for referral for acute inpatient detoxification if signs and symptoms are present that suggest the failure to use this level of treatment would be life threatening or cause permanent impairment once substance use is stopped. A Member must have all of the following criteria for inpatient detoxification:

- Fluids and medication to modify or prevent withdrawal complications that threaten life or bodily functions
- Twenty-four (24) hour nursing care with close frequent observation/monitoring of vital signs
- Medical therapy, which is supervised and re-evaluated daily, by the attending physician in order to stabilize the member's physical condition

The Member must exhibit at least two (2) or more of the following symptoms for substance withdrawal:

- Tachycardia
- Hypertension
- Diaphoresis
- Significant increase or decrease in psychomotor activity
- Tremors
- Significantly disturbed sleep patterns
- Nausea/vomiting
- Clouding of consciousness with reduced capacity to shift, focus, and sustain attention

Additionally, criteria for inpatient alcohol detoxification are based on the anticipated severity of the withdrawal as deemed by application of the Revised Clinical Institute Withdrawal Assessment for Alcohol Scale. These tools should be applied as follows:

POINTS ON SCALE	SEVERITY OF WITHDRAWAL	TREATMENT
0 – 5	No withdrawal	Outpatient
6 – 9	Mild withdrawal	Outpatient
10 – 14	Mild-to-moderate withdrawal	Outpatient treatment possible for stable, withdrawal compliant patients with no medical or psychiatric complications and no concurrent abuse of other classes drugs. One (1) day of CHB could be authorized for observation with subsequent assignment either to DCI or outpatient treatment based on reapplication of CIWA-Ar
15 – 19	Moderate-to-severe withdrawal	Hospitalize for detox. Review CIWA-Ar after three (3) days for re-determination
15 with threatened delirium tremens or score of 20+	Severe withdrawal	Hospitalize for detox. Review CIWA-Ar after three (3) days for re-determination

Once the determination and authorization has been made to refer the Member for alcohol and drug treatment services to a SD Provider/Practitioner or a FFS Provider/Practitioner, the PCP may make the referral directly, or may refer the Member to the MHC Case Manager for the coordination of services and follow-up.

According to local preference, referrals are made to a central intake center or directly to a SD/FFS Provider/Practitioner. In both cases, the County Office of Alcohol and Drug Programs will review the case to determine the appropriate level of care for the Member. The County Office of Alcohol and Drug Programs has determined specific criteria for appropriateness and need for services, including medical or service necessity, focus of care, and frequency of service.

Criteria for Admission to a Residential Facility for Treatment of Substance Use Disorders

A Member will be considered a candidate for referral if all of the following indicators apply:

- There is a pattern of substance use that meets the current Diagnostic and Statistical Manual (DSM) criteria for substance use disorder and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities
- The Member is sufficiently medically stable so that the criteria for inpatient detoxification services are not met
- There is clearly documented evidence of the failure of appropriate partial hospitalization or structured outpatient treatment for substance abuse or dependence meeting the current DSM criteria
- The Member's environment or living situation is severely dysfunctional as a result of inadequate or unstable support systems, including the work environment, which may jeopardize successful treatment on an outpatient basis
- There is significant risk of relapse if the Member is treated in a less restrictive care setting related to severely impaired impulse control or a code-morbid disorder

Criteria for Admission to a Partial Hospital Program for Treatment of Substance Use Disorders

A Member will be considered a candidate for referral if all of the following indicators apply:

- There is a clearly documented pattern of substance abuse or dependence that meets the current DSM criteria and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities
- The Member is sufficiently medically stable so that the criteria for inpatient detoxification services are not met
- The Member requires up to eight (8) hours of structured treatment per day in order to obtain the most benefit from coordinated services such as individual, group or family therapy, education, and/or medical supervision
- The Member's environment or living situation and social support system are sufficiently stable to allow for treatment in this care setting
- There is evidence of sufficient motivation for successful participation and treatment in this care setting
- The Member has demonstrated, or there is reason to believe, that the Member can avoid the abuse of substances between treatment sessions based on an assessment of factors such as intensity of cravings, impulse control, judgment, and pattern of use

Criteria for Admission to a Structured Outpatient Program for Treatment of Substance Use Disorders

A Member will be considered a candidate for referral if all of the following indicators apply:

- There is a pattern of substance use that meets the current Diagnostic and Statistical Manual (DSM) criteria for substance use disorder and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities
- The Member requires up to four (4) hours of structured treatment per day in order to obtain the most benefit from coordinated services such as individual, group, or family therapy, education, and/or medical supervision
- The Member's environment or living situation and social support system are sufficiently stable to allow for treatment in this care setting
- There is evidence of sufficient motivation for successful participation in treatment in this care setting
- The Member has demonstrated, or there is reason to believe, that the Member can avoid the abuse of substances between treatment sessions based on an assessment of factors such as intensity of cravings, impulse control, judgment and pattern use

Criteria for Inpatient Chemical Dependency Rehabilitation

A Member will be considered a candidate for referral when a combination of the following conditions have been met:

- There is evidence of a substance use disorder as described in the current DSM
- There is evidence of an inability to maintain abstinence outside of a controlled environment
- There is evidence of impairment in social, family, medical, and/or occupational functioning that necessitates skilled observation and care
- There is evidence of need for isolation from the substance of choice and from destructive home influences
- The Member has sufficient mental capacities to comprehend and respond to the content of the treatment program

Continuity of Care

Providers/Practitioners should provide services in a manner that ensures coordinated and continuous care to all members requiring alcohol and/or drug treatment services including:

- Appropriate and timely referral
- Documenting referral services in the Member's medical record
- Monitoring Members with ongoing substance abuse
- Documenting emergent and urgent encounters, with appropriate follow-up, coordinated discharge planning, and post-discharge care in the Member's medical record

Upon request, MHC Case Management staff will assist in the identification of cases that require coordination of social and health care services.

In the event that the local SD/MC treatment slots are unavailable, the PCP and MHC's Case Management's staff will pursue placement in out-of-network services until the time in-network services become available.

To assure continuity of care when a Member is referred to another Provider/Practitioner, the PCP will transfer pertinent summaries of the Member's medical record to the substance abuse Provider/Practitioner or program and, if appropriate, to the organization where future care will be rendered. Any transfer of Member medical records and/or other pertinent information will be done in a manner consistent with confidentiality standards, including a release of medical records signed by the Member.

Clinical needs and availability of follow-up care will be documented in the Member's medical record. It is recommended that the Member should be in contact with the follow-up therapist or agency prior to discharge from an inpatient facility or outpatient program.

It is expected that Members discharged from a substance abuse inpatient unit will have their follow-up care arranged by the facility's discharge coordinator. MHC recommends that the initial outpatient follow-up appointment occur no later than thirty (30) days after discharge. In addition, the facility discharge coordinator is responsible for notifying the PCP of the Member's impending discharge.

Confidentiality

- Confidential Member information includes any identifiable information about an individual's character, habits, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. Confidential member information may be learned by a staff member, in either a casual or formal setting, including conversation, computer screen data, faxes, or any written form, all of which will be treated with strict confidence
- MHC and affiliated health plan employees and contracting Providers/Practitioners and their staffs are expected to respect each Member's right of confidentially and to treat the Member information in a respectful, professional, and confidential manner consistent with all applicable Federal and State requirements. Discussion of member information will be limited to that which is necessary to perform the duties of the job
- Applicable MHC policies and procedures include Collection/Confidentiality and Release of Primary Health Care Information and Safeguarding and Protecting Departmental Records

Problem Resolution

If a disagreement occurs between MHC and the County Office of Alcohol and Drug Programs regarding responsibilities, the Utilization Management Department is notified of the problem. All medical records and correspondence should be forwarded to MHC at:

Molina Healthcare of California
Utilization Management Department
200 Oceangate, Suite 100
Long Beach, CA 90802
(844) 557-8434
(800) 811-4804 (fax)

The Utilization Management Department will:

- Review medical records for issue of discrepancy and discuss with the MHC's Medical Director
- Discuss with the State or County Mental Health Department Office of Alcohol and Drug Programs the discrepancy of authorization and the MHC Clinical Review
- Report MHC's review determination to the County Mental Health Department Office of Alcohol and Drug Programs
- Communicate State or County determinations to the PCP, MHC Medical Director, and other involved parties

Why Do We Need To Ask About Substance Abuse?

There are many forms of substance use disorder that cause substantial risk or harm to the individual. They include excessive drinking each day, repeated episodes of drinking or using drugs to intoxication, drinking or using drugs that are actually causing physical or mental harm and that has resulted in the person becoming dependent or addicted to the substance being used to excess.

In a primary care practice survey, fifteen percent (15%) of the patients had a high risk or dependent pattern of alcohol abuse and five percent (5%) had the same pattern with other drugs. Studies have shown that up to twenty-five percent (25%) of patients admitted to medical-surgical beds in hospitals either have dependence or abuse of alcohol or drugs. Substance-related disorders in the elderly remain overlooked and undertreated. Up to sixteen percent (16%) of the elderly have alcohol use disorders. With Americans age sixty-five (65) and older constituting the fastest growing segment of our population, this issue becomes increasingly important. Mortality from withdrawal increases with each additional medical condition a person has.

Screening Tools:
Included for your reference are the following:

- Red Flags for alcohol/drug abuse
- Questions to ask patients
- CAGE AID
- Drug use questionnaire (DAST-20)

RED FLAGS FOR ALCOHOL/DRUG USE DISORDERS

Observable

1. Tremor/perspiring/tachycardia
2. Evidence of current intoxication
3. Prescription drug seeking behavior
4. Frequent falls; unexplained bruises
5. Diabetes, elevated BP, ulcers
6. Frequent hospitalizations
7. Inflamed, eroded nasal septum
8. Dilated pupils
9. Track marks/injection sites
10. Gunshot/knife wound
11. Suicide talk/attempt, depression
12. Pregnancy (screen all)

Laboratory

1. MCV - over ninety-five (95)
2. MCH - High
3. GGT - High
4. SGOT - High
5. Bilirubin - High
6. Triglycerides – High
7. Anemia
8. Positive UA for illicit drug use

CAGE-AID

The CAGE-AID (Adapted to Include Drugs) is a version of the CAGE alcohol screening questionnaire, adapted to include drug use. It assesses likelihood and severity of alcohol and drug abuse.

- Target population: Adults and adolescents
- Evidence:
  - Easy to administer, with good sensitivity and specificity (Leonardson et al. 2005)
  - More sensitive than original CAGE questionnaire for substance abuse (Brown & Rounds 1995)
  - Less biased in term of education, income, and sex then the original CAGE questionnaire (Brown & Rounds 1995)
- Scoring: Each question is scored one (1) point
  - A score of (one) 1 raises suspicion of alcohol or drug abuse
  - A score of two (2)+ indicates likelihood of abuse, i.e., alcohol or drug use disorder

CAGE-AID questions to ask patients:

1. Have you ever felt you should *Cut Down* on drinking or drug use?
2. Have people *Annoyed* you by criticizing or complaining about your drinking or drug use?
3. Have you ever felt bad or *Guilty* about your drinking or drug use?
4. Have you ever had a drink or drug in the morning *(Eye Opener)* to steady your nerves or to get rid of a hangover?
5. Do you use any drugs other than those prescribed by a practitioner?
6. Has a practitioner ever told you to cut down or quit use of alcohol or drugs?
7. Has your drinking/drug use caused family, job, or legal problems?
8. When drinking/using drugs have you ever had a memory loss (blackout)?

Opioid Dependence

Opioid dependence is characterized by a cluster of cognitive, behavioral and physiological features. The CMS approved diagnostic and procedural code sheet identifies such features:

- A strong desire or sense of compulsion to take opioids
- Difficulties in controlling opioid use
- Physiological withdrawal state
- Tolerance Progressive neglect of alternative pleasures or interests because of opioid use
- Persisting with opioid use despite clear evidence of overtly harmful consequences

CMS approved diagnostic and procedural coding defines opioid dependence as the “presence of three of more [of these features] present simultaneously at any one time in the preceding year.” Opioid dependence can include both heroin and prescribed opioids. The criteria for dependence are the same whether the substance is heroin or prescribed pain medications.

Symptoms of opioid intoxication include drooping eyelids and constricted pupils, sedation, reduced respiratory rate, head nodding, and itching and scratching (due to histamine release).

Symptoms of opioid withdrawal include yawning, anxiety, muscle aches, abdominal cramps, headache, dilated pupils, difficulty sleeping, vomiting, diarrhea, piloerection (gooseflesh), agitation, myoclonic jerks, restlessness, delirium, seizures and elevated respiratory rate, blood pressure and pulse.

Drug Use Questionnaire (DAST-20)

These questions refer to the past twelve (12) months.

1.	Have you ever used drugs other than required for medical reasons?	Yes	No
2.	Have you abused prescription drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
4.	Can you get through the week without using drugs?	Yes	No
5.	Are you always able to stop using drugs when you want to?	Yes	No
6.	Have you had “blackouts” or “flashbacks” as a result of drug use?.....	Yes	No
7.	Do you feel bad or guilty about your drug use?	Yes	No
8.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9.	Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10.	Have you lost friends because of your drug use?	Yes	No
11.	Have you neglected your family because of your drug use?	Yes	No
12.	Have you been in trouble at work because of drug use?	Yes	No
13.	Have you lost a job because of drug abuse?	Yes	No
14.	Have you gotten into fights when under the influence of drugs?	Yes	No
15.	Have you engaged in illegal activities in order to obtain drugs?.....	Yes	No
16.	Have you been arrested for possession of illegal drugs?	Yes	No
17.	Have you experienced withdrawal symptoms (felt sick) when you stop taking drugs? ..	Yes	No
18.	Have you had medical problems as a result of your drug use? (e.g., memory loss, hepatitis, convulsions, bleeding, etc.).....	Yes	No
19.	Have you gone to anyone for help for a drug problem?	Yes	No

20.	Have you been involved in a treatment program specifically related to drug use?	Yes	No

Detoxification from Alcohol and Drugs

The Substance Abuse and Mental Health Services Administration (SAMHSA) Consensus Panel supports the following statement and has taken special care to note that detoxification is not substance abuse treatment and rehabilitation:

- "Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal. Supervised detoxification may prevent potentially life-threatening complications that might appear if the patient was left untreated. At the same time, detoxification is a form of palliative care (reducing the intensity of a disorder) for those who want to become abstinent or who must observe mandatory abstinence as a result of hospitalization or legal involvement. Finally, for some patients it represents a point of first contact with the treatment system and the first step to recovery. Treatment/rehabilitation, on the other hand, involves a constellation of ongoing therapeutic services ultimately intended to promote recovery for substance abuse patients."

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MAJOR ORGAN TRANSPLANTS

Organ transplants are a covered benefit of the Medi-Cal program. Under the GMC, MHC is responsible for identifying and referring patients to Medi-Cal approved facilities for evaluation. Members undergoing transplants are to be disenrolled except for kidney or cornea transplants for which MHC retains full responsibility.

The Medi-Cal program has established specific patient and facility selection criteria for each of the following Medi-Cal major organ transplants:

- Bone marrow transplants
- Heart transplants
- Liver transplants
- Lung transplants
- Heart/lung transplants
- Combined liver and kidney transplants
- Combined liver and small bowel transplants
- Small bowel transplants

Eligibility

Final authorization of major organ transplants is the responsibility of the Medi-Cal Field Office and, for children under twenty-one (21) years of age, the California Children's Services (CCS) Central Office.

The PCP is responsible for identifying members who are potential candidates for a major organ transplant, for initiating a referral to appropriate specialists and/or transplant centers, and for coordinating care. The PCP may contact the Medical Director or Care Access and Monitoring department of MHC to assist in the referral process.

Referrals

- The PCP will identify members who may be potential candidates for major organ transplant. Following the identification, the PCP will initiate a referral to a specialist and/or Medi-Cal approved transplant center and will continue to provide and coordinate care until the Member is disenrolled from the Plan
- If the transplant center deems the Member to be a potential candidate, the transplant. Provider/Practitioner will submit a request for authorization to the Medi-Cal Field Office or CCS Central Office
- Upon receipt of approval or denial of the transplant authorization request, the transplant center will immediately inform the plan so appropriate action may be taken
- If the request is denied because the Member's medical condition does not meet DHCS criteria, the Plan remains responsible for the provision of all medically necessary services to the Member
- If the request is approved, the health plan Health Care Services Staff will initiate disenrollment of the Member in accordance with MHC Policy and Procedure MS-02, Mandatory Disenrollments (including excluded services). To ensure continuity of care to the Member, the Member will be disenrolled only after the following steps have occurred:
    - The health plan CAM staff has approved a referral of the Member to a Medi-Cal designated transplant center for evaluation
    - The transplant center Provider/Practitioner(s) has performed a pre-transplant evaluation on the Plan Member and the center's Patient Selection Committee has determined the member to be a suitable candidate for transplant
    - The transplant center Provider/Practitioner(s) has submitted a prior authorization request to the appropriate state office and the transplant procedure has been approved and documentation sent to the health plan Case Management Staff by the transplant center
- The disenrollment request, accompanied by the approved authorization request, has been submitted by MHC to the Health Care Options (HCO) contractor, which will then notify MHC of receipt of the request and initiate the disenrollment process

- In the event of the necessity for an emergency organ transplant, MHC's CAM Staff will assure that medically necessary transplant services are provided in a Medi-Cal designated transplant center and that an authorization request is submitted to the appropriate State office. When an approval for the transplant, which may be retroactive, is received, the disenrollment request, accompanied by the approved authorization request, will be submitted by the health plan CAM Staff to the HCO contractor, which will notify the health plan CAM Staff of receipt of the request and initiate the disenrollment process
- The effective date of disenrollment will be retroactive to the beginning of the month in which authorization is given. MHC will retain responsibility for providing all medically necessary covered services during the month in which the transplant is authorized, and will request the HCO contractor to initiate a routine, non-retroactive disenrollment
- MHC is responsible for all costs of covered medical care, including those for transplant evaluation, organ acquisition, and bone marrow search, until the effective date of disenrollment. Services performed after the effective date of disenrollment should be billed on a FFS basis
- When the transplant has been approved and the disenrollment process has been initiated, MHC will notify the Member and coordinate the transfer of the Member's care to the transplant Provider/Practitioner
- PCPs are responsible for continuity of care during the transition period and for transferring all medical records to the transplant Provider/Practitioner
- For Members under twenty-one (21) years of age, the health plan CCS Staff will notify the local CCS program when the disenrollment process has been initiated, in order to maintain continuity of care
- Coordination of care is managed by the PCP, who is assisted by a health plan Case Manager until the Member is disenrolled from MHC

The PCP has primary responsibility for the coordination of care:
- Identification of potential Major Organ Transplants candidates
- Provision of primary medical care
- Referral to appropriate specialty care Provider/Practitioner
- Review of all medical records and reports received from transplant center
- Providing education to member regarding his/her condition
- Reinforcing the transplant team's treatment plan
- Referring member to additional psychosocial support resources as needed
- Provide all required documentation to the transplant center

The health plan CAM staff is responsible for the following:
- Referral to a contracted major organ transplant center and ensuring the appointment is scheduled appropriately
- Ensuring transfer of pertinent medical records to transplant center
- Communicating written or verbally as necessary
- Ensuring the transplant center evaluation appointment is kept by the member
- Contacting Member Services to process a member disenrollment from MHC once transplant treatment has been authorized by the Medi-Cal Field Office (if transplants are carved out of MHC's benefit coverage by contract) or the CCS Central Office
- Tracking each phase of the referral process to the transplant center(s)
- The health plan's Medical Director, CAM staff, Case Manager, and member's PCP (and Specialist if applicable) will continue to manage and coordinate member's health care needs with a contracted transplant center, if MHC's benefit coverage includes transplants by contract
- The effective date of the disenrollment is retroactive to the beginning of the month in which the transplant was approved

- If the request for a transplant is denied by the Medi-Cal Field Office or CCS, the health plan's PCP will continue to provide and coordinate the member's care
- The health plan Case Manager will continue to provide case management services until such time that the denial decision is reversed by DHCS upon appeal by the member or the member is no longer eligible

Disenrollment

If the request is approved, MHC CAM staff will initiate disenrollment of the Member. To ensure no disruption of care to the Member, the Member will be disenrolled only after the following:

- MHC CAM Staff has approved a referral of the Member to a Medi-Cal designated transplant center for evaluation

Major Organ Transplant

- The transplant center Provider/Practitioner has performed a pre-transplant evaluation on the Member and the center's Patient Selection Committee has determined the Member to be a suitable candidate for transplant
- The transplant center Provider/Practitioner has submitted a prior authorization request and the transplant procedure has been approved
- The disenrollment request, accompanied by the approved authorization request, has been submitted by MHC to the Health Care Options (HCO) contractor, which will then notify Molina of receipt of the request and initiate the disenrollment process
- Should an emergency organ transplant be necessary, MHC CAM Staff will ensure that medically necessary transplant services are provided in a Medi-Cal designated transplant center and that an authorization request is submitted to the appropriate State office

The effective date of disenrollment will be retroactive to the beginning of the month in which the authorization was given. MHC will retain responsibility for providing a Member's medically necessary covered service during the month in which the transplant authorization is given. MHC is responsible for all costs of covered medical care, including those for transplant evaluation, organ acquisition, and bone marrow search, until the effective date of disenrollment. Services performed after the effective date of disenrollment should be billed on a FFS basis.

PCP's Responsibility

PCPs are responsible for ensuring continuity of care during the transition period and for transferring all medical records to the transplant Provider/Practitioner in a timely manner.

It is the responsibility of the PCP to refer any member who is a potential transplant candidate to the CAM Department. Please contact the appropriate Case Management Department as follows:

Molina Healthcare Phone: (800) 526-8196 ext. 127604
Fax: (888) 273-1735

Renal Transplants

Renal transplants for members twenty-one (21) years and over are a covered benefit. The PCP and Case Management Staff will refer the identified member to a DHCS licensed and certified hospital with a renal transplant unit. The PCP is responsible for the coordination of all necessary primary care services and for the

provision of all services related to renal transplantation, including the evaluation of potential donors and nephrectomy from living or cadaver donors.

Members under age twenty-one (21) years in need of evaluation as potential renal transplant candidates will be referred to the appropriate CCS program office for a referral to an approved CCS renal dialysis and transplant center. Requests for renal transplants from CCS approved renal dialysis and treatment centers will be sent to the local CCS Program Office for authorization. The PCP and health plan's CCS Staff will coordinate the referral to the CCS Program Office.

MHC remains responsible for the provision of primary care services and for coordination of care with CCS regarding renal transplant services.

8.7 HEALTHCARE SERVICES: MENTAL HEALTH/SHORT-DOYLE COORDINATION & SERVICES

Effective January 1, 2014, as established in W&I Code Sections (§§) 14132.03 and 14189, Medi-Cal managed care plans, including MHC and contracted network providers, are required to cover certain outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health diagnosis, as defined in the current Diagnostic and Statistical Manual, except relational problems (i.e., couples counseling or family counseling for relational problems).

As of October 1, 2017, the Medicaid Mental Health Parity Final Rule (CMS-2333-F), establishes the regulatory requirements for the provision of medically necessary non-specialty mental health services to children under the age of twenty-one (21). The number of visits for mental health services is not limited as long as the MHC beneficiary meets medical necessity criteria. MHC provides direct access to an initial mental health assessment by a licensed mental health provider within network. Referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provided is not required.

As of January 1, 2014, MHC is offering the following expanded mental health services to Medi-Cal managed care members meeting medical necessity or Early Periodic Screening Diagnosis and Treatment (EPSDT) and/or members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health diagnosis, as defined in the current Diagnostic and Statistical Manual, except relational problems (i.e., couples counseling or family counseling for relational problems):

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication therapy
- Outpatient services that include laboratory work, medications (excluding anti-psychotic drugs which are covered by Medi-Cal FFS), supplies and supplements
- Psychiatric consultation
- Screening and brief intervention

The following specialty mental health services are excluded from MHC's coverage responsibility, but will continue to be provided by the County mental health agencies for members who meet medical necessity criteria or EPSDT and/or members with severe impairment of mental, emotional, or behavioral functioning resulting from a mental health diagnosis. MHC contracted providers should direct members who are receiving or eligible for such services to County mental health/behavioral health services.

- Outpatient services
  - Mental health services, including assessments, plan development, therapy and rehabilitation, and collateral
  - Medication support
  - Day treatment services and day rehabilitation
  - Crisis intervention and stabilization
  - Targeted case management
  - Therapeutic behavior services
- Residential services
  - Adult residential treatment services
  - Crisis residential treatment services
- Inpatient services
  - Acute psychiatric inpatient hospital services

- Psychiatric inpatient hospital professional services.
- Psychiatric health facility services.

The following services are excluded from MHC's coverage responsibility, but are provided by County Alcohol and Other Drug (AOD) programs:

- Outpatient services
  - Outpatient drug-free program.
  - Intensive outpatient (newly expanded to additional populations).
  - Residential services (newly expanded to additional populations).
  - Narcotic treatment program.
  - Naltrexone
- New Services
  - Voluntary inpatient detoxification

Primary care providers continue to be responsible for screening and brief intervention, and in performing all preliminary evaluations necessary to develop a diagnosis prior to referring member to applicable county agency or program. Screening tools are available on the DHCS and our provider website at www.MolinaHealthcare.com. Screening tools include the Staying Healthy Assessment/Individual Health Education Behavioral Assessment (IHEBA). Please refer to the released guidelines regarding the use of the IHEBA in Policy Letter (PL) 13-001 (Revised) and the "New Requirements for the Staying Healthy Assessment/Individual Health Education Behavioral Assessment."

Psychiatric Scope of Services for the PCP

These services are limited; examples of services that are generally considered psychiatric primary care services are listed below. However, the PCP must have received appropriate training and provide only those services consistent with State and Federal regulations and statutes:

- Perform complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, over-eating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems)
- Diagnose physical disorders with behavioral manifestations
- Provide maintenance medication management after stabilization by a psychiatrist or if longer-term psychotherapy continues with a non-Practitioner therapist
- Diagnose and manage child/elder/dependent-adult abuse and victims of domestic violence
- Screening for depression for pregnant and post-partum patients and referral to treatment when indicated

PCP Responsibilities – Primary Caregiver and Referrals

PCPs will provide outpatient mental health services within their scope of practice. Should the Member's mental health needs require specialty mental health services (as indicated above), the PCP should refer the Member to the County Mental Health Department for assessment and referral to an appropriate mental health Provider/Practitioner. The PCP will make available all necessary medical records and documentation relating to the diagnosis and care of the mental health condition resulting in a referral.

The PCP will assure appropriate documentation in the Member's medical record. The PCP will coordinate non-SD/MC conditions and services with specialists as necessary.

Continuation of Care

PCPs will provide services and referrals in a manner that ensures coordinated and continuous care to all Members needing mental health services, including appropriate and timely referral, documentation of referral services, monitoring of Members with ongoing medical conditions, documentation of emergency and urgent encounters with appropriate follow-up, coordinated discharge planning, and post-discharge care.

To assure continuity of care when a Member is referred to another Provider/Practitioner, the PCP will transfer pertinent summaries of the Member's records to that health care Provider/ Practitioner and, if appropriate, to the organization where future care will be rendered. Any transfer of Member medical records and/or other pertinent information should be done in a manner consistent with confidentiality standards including a release of the medical records signed by the Member.

Confidentiality

Confidential Member information includes any identifiable information about an individual's character, habits, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment.

It is the policy of MHC that all of its employees and contracting Provider/Practitioners respect each Member's right of confidentiality and treat the Member information in a respectful, professional, and confidential manner consistent with all applicable Federal and State requirements. Discussion of member information should be limited to that which is necessary to perform the duties of the job.

Reports from specialty services and consultations are placed in the patient's chart at the PCP's office. Mental health services are considered confidential and sensitive. Any follow-up consultation that the PCP receives from the specialist or therapist is placed in the confidential envelope section of the Member's medical record. Please refer to MHC Policy and Procedure MR-26, Collection/Use/Confidentiality, and Release of Primary Health Information and MS-07, Safeguarding and Protecting Medical Records.

Problem Resolution

If a disagreement occurs between MHC and the California Department of Mental Health regarding responsibilities, the Utilization Management Department is notified. All medical records and correspondence should be forwarded to:

Molina Healthcare of California
Attn: Utilization Management Department
200 Oceangate, Suite 100
Long Beach, CA 90802
Telephone: (844) 557-8434
Fax: (800) 811-4804

The Utilization Management Department shall:

- Review medical records for issue of discrepancy and discuss with MHC Medical Director
- Discuss with the California Department of Mental Health the discrepancy of authorization responsibility and the MHC clinical review determinations
- MHC will authorize all services that are medically necessary that are not excluded from the contract agreement for Medi-Cal managed care
- If a dispute cannot be resolved to the satisfaction of the California Department of Mental Health or MHC, a request by either party may be submitted to the Department of Health Care Services within fifteen (15) calendar days of the completion of the dispute resolution process outlined in the applicable Memorandum of

Understanding (MOU) (the request for resolution shall contain the items identified in Title 9. CCR Section 1850.505)

- MHC will communicate issues and determinations to the PCP and other involved parties

8.8 HEALTHCARE SERVICES: BREAST & PROSTATE CANCER TREATMENT INFORMATION REQUIREMENTS

SPECIAL REQUIREMENTS FOR INFORMATION AND/OR CONSENT FOR BREAST AND PROSTATE CANCER TREATMENT

Breast Cancer Consent Requirements

A standardized summary discussing alternative breast cancer treatments and their risks and benefits must be given to patients. A brochure has been prepared to accomplish this task and is available at the following address:

Medical Board of California
Breast Cancer Treatment Options
1426 Howe Street, Suite 54
Sacramento, CA 95825

Order requests can be faxed to (916) 263-2479. There is no charge for the brochure and it is available in bundles of twenty-five (25), up to a maximum of two (2) cases – two-hundred-fifty (250) copies per case. It is available in the following languages: English, Spanish, Korean, Chinese, Russian, and Thai.

The brochure should be given to the patient before a biopsy is taken, whether or not treatment for breast cancer is planned or given. The brochure may not supplant the physician's duty to obtain the patient's informed consent. In addition to the distribution of the brochure, physicians should discuss the material risks, benefits, and possible alternatives of the planned procedure(s) with the patient and document such discussion in the medical record of the patient. Failure to provide the required information constitutes unprofessional conduct.

Every physician who screens or performs biopsies for breast cancer must post a sign with prescribed wording relating to the above brochure. The sign or notice shall read as follows:

"BE INFORMED"

"If you are a patient being treated for any form of breast cancer, or prior to performance of a biopsy for breast cancer, your physician and surgeon is required to provide you a written summary of alternative efficacious methods of treatment, pursuant to Section 109275 of the California Health and Safety Code."

"The information about methods of treatment was developed by the State Department of Health Care Services to inform patients of the advantages, disadvantages, risks, and descriptions of procedures."

The sign must be posted close to the area where the breast cancer screening or biopsy is performed or at the patient registration area. The sign must be at least 8 1/2" X 11" and conspicuously displayed so as to be readable. The words "BE INFORMED" shall not be less than one-half inch in height and shall be centered on a single line with no other text. The message on the sign shall appear in English, Spanish, and Chinese.

Prostate Cancer Screening and Treatment Information to Patients

Providers/Practitioners are required to tell patients receiving a digital rectal exam that a prostate-specific antigen (P.S.A.) test is available for prostate cancer detection.

The National Institute of Health currently provides a prostate cancer brochure entitled: “What You Need to Know about Prostate Cancer.” It is available by calling (800) 4CANCER. Brochures can also be ordered by going online to www.cancer.gov or faxing an order to (301) 330-7968. The first twenty (20) brochures are free and there is a $.15/brochure fee for orders over twenty (20), with a minimum order of $8.00.

Every physician who screens for or treats prostate cancer must post a sign with prescribed wording referencing this information. The sign or notice shall read as follows:

“BE INFORMED”

“If you are a patient being treated for any form of prostate cancer, or prior to performance of a biopsy for prostate cancer, your physician and surgeon is urged to provide you a written summary of alternative efficacious methods of treatment, pursuant to Section 109280 of the California Health and Safety Code.”

“The information about methods of treatment was developed by the State Department of Health Care Services to inform patients of advantages, disadvantages, risks, and descriptions of procedures.”

The sign must be posted close to the area where the prostate cancer screening or treatment is performed or at the patient registration area. The sign must be at least 8 1/2” X 11” and conspicuously displayed so as to be readable. The words “BE INFORMED” shall not be less than one-half inch in height and shall be centered on a single line with no other text. The message on the sign shall appear in English, Spanish, and Chinese. The sign shall include the internet web site address of the State Department of Health Care Services and the Medical Board of California and a notice regarding the availability of updated prostate cancer summaries on these web sites.

Information for Patients

The California Department of Public Health (CDPH) has information about breast and prostate cancer on their website at: http://www.cdph.ca.gov/HealthInfo/Pages/BreastCancerInformation.aspx

Information can be viewed or printed from this website.

8.9 HEALTHCARE SERVICES: HUMAN REPRODUCTIVE STERILIZATION PROCEDURE & CONSENT

Members must be appropriately and adequately informed about human reproductive sterilization procedures. Informed consent must be obtained prior to performing a procedure that renders a person incapable of producing children. Sterilization performed because pregnancy would be life threatening to the mother is included in this requirement. When sterilization is the unavoidable secondary result of a medical procedure and the procedure is not being done in order to achieve that secondary result, the procedure is not included in this policy.

Conditions for Sterilization

Sterilization may be performed only under the following conditions:

- The Member is at least twenty-one (21) years old at the time the consent is obtained
- The Member is not mentally incompetent, as defined by Title 22, i.e., an individual who has been declared mentally incompetent by a Federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared incompetent for purposes which include the ability to consent to sterilization
- The Member is able to understand the content and nature of the informed consent process
- The Member is not institutionalized, as defined by Title 22, i.e., someone who is involuntarily confined or detained, under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness
- The Member has voluntarily given informed consent in accordance with all of the prescribed requirements
- At least thirty (30) days, but not more than one-hundred-eighty (180) days, have passed between the date of written informed consent and the date of the sterilization. Exceptions are addressed below

Conditions When Informed Consent May Not Be Obtained

Informed consent may not be obtained while the member to be sterilized is:

- In labor or within twenty-four (24) hours postpartum or post-abortion
- Seeking to obtain or obtaining an abortion
- Under the influence of alcohol or other substances that affect the member’s state of awareness

Informed Consent Process Requirements

The following criteria, including the verbal and written member information requirements, must be met for compliance with the informed consent process:

- The informed consent process may be conducted either by Provider/Practitioner or appropriate designee
- Suitable arrangements must be made to ensure that the information specified above is effectively communicated to any individual who is deaf, blind, or otherwise handicapped
- An interpreter must be provided if the member to be sterilized does not understand the language used on the consent form or the language used by the person obtaining the consent
- The member to be sterilized must be permitted to have a witness present of that member’s choice when consent is obtained
- The sterilization procedure must be requested without fraud, duress, or undue influence

Required Member Information

The Member requesting to be sterilized must be provided with the appropriate booklet on sterilization published by the Department of Health Care Services (DHCS) BEFORE THE CONSENT IS OBTAINED. These are the only information booklets approved by DHCS for distribution to individuals who are considering sterilization:

- "Understanding Sterilization for a Woman"
- "Entendiendo La Esterilizacion Para La Mujer"
- "Understanding Vasectomy"
- "Entendiendo La Vasectomia"

Providers/Practitioners may obtain copies of the information booklets provided to Members in English or Spanish by submitting a request on letterhead to:

California Department of Health Care Services
Warehouse - Forms Processing
1037 North Market Blvd., Suite 9
Sacramento, CA 95834
Fax: (916) 928-1326

When the Providers/Practitioners or appropriate designee obtains consent for the sterilization procedure, he/she must offer to answer any questions the Member to be sterilized may have concerning the procedure. In addition, all of the following must be provided verbally to the Member who is seeking sterilization:

- Advice that the Member is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits, he/she is entitled to
- A full description of available alternative methods of family planning and birth control
- Advice that the sterilization procedure is considered irreversible
- A thorough explanation of the specific sterilization procedure to be performed
- A full description of discomforts and risks that may accompany or follow the procedure, including explanation of the type and possible side effects of any anesthetic to be used
- A full description of the benefits or advantages that may be expected from sterilization
- Approximate length of hospital stay and approximate length of time for recovery
- Financial cost to the member. Information that the procedure is established or new
- Advice that sterilization will not be performed for at least thirty (30) days, except in the case of emergency abdominal surgery or premature birth (when specific criteria are met)
- The name of the Provider/Practitioner performing the procedure. If another Provider/ Practitioner is to be substituted, the member will be notified, prior to administering pre-anesthetic medication, of the Provider/Practitioner's name and the reason for the change in Provider/Practitioner

The required consent form PM 330 must be fully and correctly completed after the above conversation has occurred. Consent form PM 330, provided by DHCS in English and Spanish, is the ONLY form approved by DHCS.

The PM 330 must be signed and dated by:

- The Member to be sterilized
- The interpreter, if utilized in the consent process
- The person who obtained the consent
- The Provider/Practitioner performing the sterilization procedure

By signing consent form PM 330, the person securing the consent certifies that he/she has personally:

- Advised the Member to be sterilized, before that Member has signed the consent form, that no Federal benefits may be withdrawn because of a decision not to be sterilized
- Explained verbally the requirements for informed consent to the Member to be sterilized as set forth on the consent form PM 330
- Determined to the best of his/her knowledge and belief, that the Member to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized

The Provider/Practitioner performing the sterilization certifies, by signing the consent form PM 330, that:

- The Provider/Practitioner, within seventy-two (72) hours prior to the time the Member receives any preoperative medication, advised the member to be sterilized that Federal benefits would not be withheld or withdrawn because of a decision not to be sterilized
- The Provider/Practitioner explained verbally the requirements for informed consent as set forth on the consent form PM 330
- To the best of the Provider/Practitioner's knowledge and belief, the Member to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized
- At least thirty (30) days have passed between the date of the Member's signature on the consent form PM 330 and the date upon which the sterilization was performed, except in the case of emergency abdominal surgery or premature birth, and then only when specific criteria is met

The interpreter, if one is utilized in the consent process, will sign the consent form PM 330 to certify that:

- The interpreter transmitted the information and advice presented verbally to the Member
- The interpreter read the consent form PM 330 and explained its content to the Member
- The interpreter determined, to the best of the interpreter's knowledge and belief, that the Member to be sterilized understood the translated information/instructions

Medical Record Documentation

There must be documentation in the progress notes of the Member's medical record that a discussion regarding sterilization has taken place, including the answers given to specific questions or concerns expressed by the Member. It will be documented that the booklet and copy of the consent form were given to the Member. The original signed consent form must be filed in the Member's medical record. A copy of the signed consent form must be given to the Member and a copy is placed in the Member's hospital medical record at the facility where the procedure is performed.

If the procedure is a hysterectomy, a copy of the informed consent form for hysterectomy should be placed in the Member's medical record. This form is supplied by the facility performing the procedure.

Office Documentation

All participating Providers/Practitioners are responsible for maintaining a log of all human reproductive sterilization procedures performed. A sample of sterilization log is provided for your reference. This log must indicate the Member's name, date of sterilization procedure, the member's medical record number, and the type of procedure performed.

Exceptions to Time Limitations

Sterilization may be performed at the time of emergency abdominal surgery or premature delivery if the following requirements are met:

- A minimum of seventy-two (72) hours have passed after written informed consent to be sterilized, and,
- A written informed consent for sterilization was given at least thirty (30) days before the member originally intended to be sterilized, or,
- A written informed consent was given at least thirty (30) days before the expected date of delivery

Special Considerations, Hysterectomy

A hysterectomy will not be performed solely for the purpose of rendering an individual permanently sterile. If a hysterectomy is performed, a hysterectomy consent form must be completed in addition to other required forms.

Noncompliance

The Quality Improvement Department monitors compliance for the consent process of human reproductive sterilization. Identified deficiencies will be remedied through a course of corrective action(s) as determined appropriate by the Quality Improvement Committee with following reviews conducted to assess improvement or continued. The DHCS also performs audits for compliance with Title 22. Both MHC and DHCS are required to report non-complaint Providers/Practitioners to the Medical Board of California.

Ordering of Consent Forms

Sterilization consent forms PM 330, with English printed on one (1) side and Spanish on the other side, can be ordered directly from DHCS by sending a request to:

Medi-Cal Benefits Branch
California Department of Health Care Services
714 P Street, Room 1640
Sacramento, CA 95814

9.0 PHARMACY/FORMULARY

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

Pharmacy and Therapeutics Committee

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

Pharmacy Network

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting www.MolinaHealthcare.com or calling Molina at (855) 322-4075.

Drug Formulary

The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit www.MolinaHealthcare.com.

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

Formulary Medications

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

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

Quantity Limitations

Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

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

Non-Formulary Medications

Nonformulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity.

Generic Substitution

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

New to Market Drugs

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

Medications Not Covered

Medications not covered by Medi-Cal are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are not part of the benefit.

Submitting a Prior Authorization Request

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

- Member first name, last Name, date of birth and identification number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity and directions of use
- Diagnosis

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing Molina will either fax or call your office to request clinical information be sent into complete review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.
Fax a completed Medication PA Request form to Molina at (866) 508-6445. A blank Medication PA Request Form may be obtained by accessing www.MolinaHealthcare.com or by calling (855)-322-4075 option #1, #2, #2 (CA Medicaid) or option #3, 2, 2 (CA Marketplace).

Member and Provider "Patient Safety Notifications"

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

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by Molina through the pharmacy benefit using national drug codes (NDCs) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications maybe covered through the medical benefit using Healthcare Common Procedure Coding System (HCPC) J-codes via paper or electronic medical claim submission.

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

If it is determined to be a Pharmacy benefit, Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations representative with any further questions about the program.

Newly FDA approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee. "Buy-and-bill" drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursement.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at www.MolinaHealthcare.com under the Health Resource tab. Please consult with your Provider Services representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

10.0 CLAIMS & COMPENSATION

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

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

Hospital- Acquired Conditions and Present on Admission Program

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

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

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility
4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries Burn
    e) Other Injuries
6) Manifestations of Poor Glycemic Control
    a) Hypoglycemic Coma
    b) Diabetic Ketoacidosis
    c) Non-Ketotic Hyperosmolar Coma
    d) Secondary Diabetes with Ketoacidosis
    e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis

10) Surgical Site Infection Following Certain Orthopedic Procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a) Laparoscopic Gastric Restrictive Surgery
    b) Laparoscopic Gastric Bypass
    c) Gastroenterostomy
12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13) Iatrogenic Pneumothorax with Venous Catheterization
14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement

What this means to Providers:

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

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: http://www.cms.hhs.gov/HospitalAcqCond/.

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or Molina's Provider Portal whenever possibleand use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 38333. For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card.

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

Required Elements

The following information must be included on every claim:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges

- Place and type of service code
- Days or units as applicable
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI)
- Rendering Provider name as applicable
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- E-signature
- Service Facility Location information

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim; and any paper claim submissions could be denied.

National Provider Identifier (NPI)

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

Electronic Claims Submission

Molina strongly encourages participating Providers to submit Claims electronically, including secondary claims. Electronic Claims submission provides significant benefits to the Provider including:

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

Molina offers the following electronic Claims submission options:
- Submit Claims directly to Molina via the Provider Portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID #38333

Provider Portal

Molina's Provider Portal offers a number of claims processing functionalities and benefits:
- Available to all Providers at no cost
- Available twenty-four (24) hours per day, seven (7) days per week
- Ability to add attachments to claims (Provider Portal and clearinghouse submissions)
- Ability to submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim.

Clearinghouse

Molina uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. In order to ensure that all data being submitted to our gateway is received properly your submitter must utilize the latest version of the 837 standards. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the claims from your clearinghouse
- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues

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

Paper Claim Submissions

If electronic claim submission is not possible, please submit paper claims to the following address:

Molina Healthcare of California
PO Box 22702
Long Beach, CA 90801

Please keep the following in mind when submitting paper claims:

- Paper claims should be submitted on original red colored CMS 1500 claims forms
- Paper claims must be printed, using black ink

Coordination of Benefits and Third-Party Liability

COB

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

Third Party Liability

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

Workers' Compensation Recovery Program (WCRP) DHCS

DHCS retains sole lien/claim rights in WC matters involving a Medi-Cal managed care member pursuant to Welfare and Institutions Code (WIC) Sections14124.70 – 14124.791, which allows DHCS to file a claim for reimbursement of Medi-Cal paid services resulting from the work-related injury of a Medi-Cal member.

A duplicate payment occurs when the WC carrier and/or employer pays the MCP provider directly for services provided to a Medi-Cal managed care member enrolled in an MCP. If this occurs, the MCP provider or subcontractor may not retain the duplicate payment.

MCPs and their subcontractors are contractually required to notify DHCS within 10 days of the date of knowledge that a third party may be liable for reimbursement to DHCS for Medi-Cal paid services provided to a Medi-Cal managed care member. The notification shall be sent to the following address:

Department of Health Care Services
Third Party Liability and Recovery Division
Workers' Compensation Recovery Program, MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate claims. Molina requires coding of both diagnoses and procedures for all claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient claims. Inpatient hospital claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Molina utilizes a claims adjudication system that encompasses edits and audits that follow State and Federal requirements and also administers payment rules based on generally accepted principles of correct coding. Payment rules based on generally accepted principles of correct coding include, but are not limited to, the following:

- Manuals and RVU files published by the Centers for Medicare and Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit, the professional organization standard may be used
  - In the absence of State guidance, Medicare National Coverage Determinations (NCDs)
  - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs)
  - CMS Physician Fee Schedule Relative Value File (RVU) indicators

- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

General Coding Requirements

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

CPT and HCPCS Codes

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

Modifiers

Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

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

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

ICD-10-CM/PCS codes

Molina utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny claims that do not meet Molina's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

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

Type of Bill

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

Revenue Codes

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

Diagnosis Related Group (DRG)

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

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

NDC
The 11 digit National Drug Code Number (NDC) must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04 or its electronic equivalent.

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

Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Claim Auditing

Molina shall use established industry claims adjudication and/or clinical practices, Commonwealth, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding and payment.

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

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This sample gives an estimate of the proportion of claims Molina paid in error. The estimated proportion, or error rate, may be projected across all claims to determine the amount of overpayment.

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

Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

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

Corrected Claims

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

correct Resubmission Code for an 837P. **Claims submitted without the correct coding will be returned to the Provider for resubmission.**

EDI (Clearinghouse) Submission

837P

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
  - "1"-ORIGINAL (initial claim)
  - "7"–REPLACEMENT (replacement of prior claim)
  - "8"-VOID (void/cancel of prior claim)

- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN)

837I

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1" "7" or "8" goes in the third digit for "frequency"
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN)

Timely Claim Processing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within one-hundred-eighty (180) calendar days after the discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within one-hundred-eighty (180) calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within forty-five (45) standard days after receipt of Clean Claims.

The receipt date of a Claim is the date Molina receives notice of the Claim.

Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment,

and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at www.MolinaHealthcare.com or by contacting our Provider Services Department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a claim for such Overpayment.

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

If a provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the Overpayment amount(s) against future payments made to the provider.

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

Claim Dispute/Reconsiderations

Providers disputing a Claim previously adjudicated must request such action within state and contract requirements of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider website and the Provider Portal. *The form must be filled out completely in order to be processed*.

Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following documentation:

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

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

Molina Healthcare of California
Attention: Claims Disputes/Adjustments
PO Box 22722
Long Beach, CA 90802

Submitted via Fax: (562) 499-0633
Electronic Submission for single claim disputes can be uploaded via the provider portal:
Provider Portal

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

The Provider will be notified of Molina's decision in writing within state and contract requirements of receipt of the Claims Dispute/Adjustment request.

Billing the Member

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

Fraud and Abuse

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

Encounter Data

Each Provider, capitated Provider, or/organization delegated for Claims processing is required to submit Encounter data to Molina for all service provided to a Molina member. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least once per month, and within (60) days from the date of service in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina should be reported.

Molina has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and propriety formats if needed.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within the sixty (60) days from date of service.

Molina has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

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

10.1 ENCOUNTER DATA

ENCOUNTER DATA INCENTIVES, CHDP INCENTIVES

Encounter Reporting

The collection of encounter data is vital to Molina Healthcare of California (MHC). Encounter data provides the Plan with information regarding all services provided to our membership. Encounter data serves several critical needs. It provides:

- Information on the utilization of services
- Information for use in HEDIS studies
- Information that fulfills state reporting requirements

DHCS has implemented standards for the consistent and timely submission of Medi-Cal encounter data. Providers must submit accurate and timely encounter data of the rendered service. MHC is required to submit encounter information to DHCS.

HIPAA Standards for Electronic Transactions

HIPAA required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. All covered entities must be in compliance with the electronic transactions and code sets standards by October 16, 2003. Covered entities include:

- health plans,
- health care providers who transmit health information in electronic form in connection with a transaction covered by HIPAA, and,
- Health care clearinghouses

The electronic health care transactions covered under HIPAA that may affect provider organizations are:

TRANSACTION DESCRIPTION	HIPAA TRANSACTION STANDARD
Claims or Encounter Information	ASC X12N 837, Professional, or Institutional Health Care Claims or Encounter ((005010X222A1/005010X223A2/005010X224A2))
Eligibility for a Health Plan	ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response (005010X279A1
Referral Certification and Authorization	ASC X12N 278 Health Care Services Review Request for Review and Response (005010X217E2)
Claims Status	ASC X12N 276/277 Health Care Claim Status Request and Response ((005010X212E2)
Payment and Remittance Advice	ASC X12N 835 Health Care Claim Payment/Advice (005010X221A1)

HIPAA Provider Hotline Contact Information

For HIPAA TCS questions please call the Toll-Free HIPAA Provider Hotline at: (866) 665-4622.
You may also obtain information on the MHC website at: www.MolinaHealthcare.com.

Policy

MHC requires all Providers/Practitioners and delegated entities to submit encounter data reflecting the care and services provided to our Members.

This policy applies to all Primary Care Practitioners (PCPs), contracted either directly with MHC or through an IPA/Medical Group and delegated entities required to submit encounters. It is important to note the encounter data must also reflect services provided by any ancillary personnel that are under the direction of the PCP, including any physicians (specialists) providing care and services to our patients as defined in their contract with MHC.

Effective July 1, 2012, services provided in an inpatient setting that can be deemed provider preventable must be identified through encounter data submissions and by completing the Medi-Cal PPC Reporting Form DHCS 7107. MHC will screen the encounter data received from network providers for the presence of the Health Care Acquired Conditions and Other Provider Preventable Conditions listed on Form DHCS 7107. Form DHCS 7107 must be completed and sent to MHC upon discovery of the preventable condition as this information will be subject to audit by DHCS. More information regarding this requirement is available APL-15-006 on the DHCS website.

Procedure

Single encounter (for our purposes) is defined as all services performed by a single Provider/ Practitioner on a single date of service for an individual Member.

The following guidelines are provided to assist our Providers/Practitioners with submission of complete encounter data:

- Reporting of services must be done on a per Member, per visit basis
- A reporting of all services rendered by date must be submitted to MHC
- Encounter Data must reflect same data elements required under a fee-for-service program
- All encounter data reporting is subject to, and must be in full compliance with, the Health Insurance Portability and Accountability Act and any other regulatory reporting requirements

Electronic Encounter Reporting is Subject to the Following Requirements:

- Data must be submitted in the HIPAA compliant 837 format (ASC X12N 837)
- DHCS mandated values must be used when appropriate (e.g., procedure code modifiers)
- Electronic encounter data must be received no later than sixty (60) days from the date of services.
- Only encounter records that pass MHC edits will be included in the records evaluated for compliance.
- Encounters that fail MHC edits will be rejected and responses be supplied back utilizing the standard 999 acknowledgement and 277CA response files
- Rejected encounters must be corrected and resubmitted within sixty (60) days from the date of services to be included in the performance standards
- In no event will incomplete, inaccurate data be accepted

All providers are required submit encounters via EDI and have the ability to submit adjustments, voids/reversal transactions.

If a Clearinghouse is used to process your electronic encounter or claims to MHC, please ensure that your contracted Clearinghouse uses the correct Payer ID for the type of EDI transactions (FFS Claims vs. Encounter):

- FFS claims Payer ID: 38333
- Encounters Payer ID: 33373

Sanctions

Providers/Practitioners will be sanctioned for noncompliance. These sanctions may include ineligibility from Molina's incentive programs, freezing new enrollment, capitation withhold, and/or ultimately terminating the capitation contract.

CHILDREN'S HEALTH AND DISABILITY PREVENTION (CHDP) SUBMISSION

The California Department of Health Care Services (DHCS) requires that all Medi-Cal Members zero (0) through their twentieth ($20^{th)}$ year and eleven (11) months receive periodic health screening exams. Exams performed must meet the requirements of this program utilizing components of the Children's Health and Disability Prevention (CHDP), a part of Children's Medical Services State Program, the American Academy of Pediatricians (AAP) Periodicity Table for Wellness Exams, and the American Academy of Pediatrician Periodicity and Recommendations for Immunizations.

All Wellness (CHDP) exams for MHC Medi-Cal Members must be documented on an encounter or claim form.

CHDP Submission to MHC

- Provider's must use the standard claim and/or encounters to submit CHDP services
- If a PCP is contracted with an IPA/Medical Group, the PCP should follow their respective IPA/Medical Group's data submission guidelines
- All providers should submit timely claims and/or encounter data through normal and current reporting channels to ensure the receipt of incentive payouts by MHC

CHDP Incentive Program

- *Please refer to MHC's P4P Program for details.*

11.0 COMPLIANCE

OVERSIGHT and MONITORING

The Medi-Cal Contract between the Department of Health Care Services (DHCS) and Molina Healthcare of California (MHC) defines a number of performance requirements that must be satisfied by both MHC and those Providers/Practitioners and IPA/Medical Groups/Hospitals agreeing, through delegated contractual relationships (or subcontracts), to provide services to eligible and enrolled MHC members. Among these are:

- The Provider/Practitioner's agreement to participate in medical and other audits (e.g. Health Effectiveness Data and Information Set (HEDIS) and/or mandated) conducted by DHCS, other regulatory agencies, or MHC
- The Provider/Practitioner's agreement to maintain books and records for a period of seven (7) years and make such documents available to regulatory agencies and MHC
- The Provider/Practitioner's agreement to furnish MHC with encounter data. Providers/Practitioners are encouraged to review their contracts with MHC to become thoroughly familiar with these and additional performance requirements
- The Provider/Practitioner's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor

Compliance Reporting Requirements for IPAs/Medical Groups/Hospitals

MHC routinely monitors its network of delegated capitated IPAs/Medical Groups/Hospitals for compliance with various standards. These requirements include but are not limited to:

1. MHC requires the delegated capitated IPAs/Medical Groups/Hospitals to submit monthly claims timeliness reports. These reports are due to MHC by the 15th of each month for all claims processed in the previous month. Ninety percent (90%) of claims are to be processed within thirty (30) calendar days of receipt. One hundred percent (100%) of all claims are to be processed within forty-five (45) working days. Refer to the Claims Section for MHC's claim processing requirements MHC requires the delegated capitated IPAs/Medical Groups/Hospitals to achieve passing claims audit scores. Claims audits are conducted annually. More frequent audits are conducted when the IPA/Medical Group/Hospital has deficiencies and/or does not achieve the timely processing requirements referenced above
2. Claims Settlement Practices and Dispute Resolution Mechanism
    a. MHC requires IPAs/Medical Groups/Hospitals to submit quarterly claims timeliness reports. These reports are due to MHC on or before the last calendar day of the month after the last month of each calendar quarter
    b. The Designated Principal Officer for Claims Settlement Practices must sign the Quarterly Claims Reports
    c. MHC also requires IPAs/Medical Groups/Hospitals to submit quarterly Provider Dispute Resolution Reports. These reports are also due on or before the last calendar day of the month after the last month of each calendar quarter
    d. The Designated Principal Officer for the Dispute Resolution Mechanism must sign the Quarterly Provider Dispute Resolution Reports
    e. These quarterly reports are due as follows:

Calendar Quarter	Due Date
First Quarter	April 30

Second Quarter	July 31
Third Quarter	October 31
Fourth Quarter	January 31

f. MHC will conduct an annual PDR audit. More frequent audits will be conducted when the IPA/Medical Group/Hospital does not meet the PDR requirements.

3. Financial Reporting/Viability

a. Quarterly financial statements are due to MHC within forty-five (45) calendar days from the end of the IPA's/Medical Group's/Hospital's fiscal quarter. The quarterly financial statements need not be certified by outside auditors but must be accompanied by a financial statement certification form signed by the Chief Financial Officer or President of the IPA/Medical Group/Hospital. Audited annual statements are due within one hundred twenty (120) calendar days, but no later than one-hundred-fifty (150) days, from the end of each IPA's/Medical Group's/Hospital's fiscal year. The audited annual statement must include footnote disclosures, and be prepared by an independent Certified Public Accountant in accordance with generally accepted accounting principles (GAAP)

All statements must be submitted on time and meet SB 260 and MHC's viability standards: 1) current assets are greater than current liabilities and 2) tangible net equity is positive. Quarterly viability cannot be determined if the organization has not submitted their most recent annual audited statement

In accordance with SB 260 (Financial Solvency Reporting), the IPA/Physician Group must also submit a quarterly financial survey report to the Department of Managed Health Care (DMHC) within forty-five (45) calendar days from the end of the IPA/Physician Group's fiscal quarter

The IPA/Physician Group must also submit an annual financial survey report to DMHC within one-hundred-fifty (150) calendar days from the end of the IPA/Physician Group's fiscal year

The IPA/Physician Group must also submit a copy to MHC of their DMHC certification and/or financial survey which will show that the quarterly and/or annual survey has been completed on DMHC's web site. In addition, MHC will also review each IPA/Physician Group's cash-to-claims ratio, which is determined based on receivables collectable within sixty (60) days according to the Balance Sheet and Grading Criteria from the DMHC financial survey

4. Utilization Management Reporting

a. MHC's Delegation Oversight Department is responsible for oversight and monitoring of delegated activities to ensure specific structures and mechanisms are in place to monitor IPA performance and compliance. This includes systematic monitoring of business functions and annual audits of each delegated IPA/Medical Group and Plan Partners, to ensure their ability to perform delegated functions and adherence to all applicable regulatory and accreditation standards

b. In order to achieve and maintain delegation status for UM activities the delegate must demonstrate the ongoing, and fully functional systems are in place, and meet the all required UM operational standards and reporting requirements

c. MHC requires capitated/delegated IPA/Medical Groups to submit utilization management reports in accordance with their Utilization Management Delegation Agreement. UM delegated entities that are required to submit reports on an annual, quarterly, and monthly basis. These include but are not limited to:

- Annually: Delegated IPA/MG are required to submit their UM Program Evaluation (from the prior year), UM Program and UM Workplan (for the current year). The UM Program must include all components required by Accreditation, State, and Federal agencies
- Quarterly: Updates to the UM Workplan are submitted on a quarterly basis. Results for UM metrics are reported, including key findings and analysis, and planned interventions if goals are not met
- Monthly: Delegated entities are required to submit a number of logs on a monthly basis. These include, but are not limited to, authorization logs and denial logs. These logs are reviewed by the nursing staff to ensure that requirements are being met; including, but not limited to, mandated turnaround times

MHC conducts its own Quality Improvement (QI) program. The IPA/Medical Groups and Providers/ Practitioners agree to abide by and participate in MHC's QI program.

Quality Oversight Monitoring

Under the terms of its contract with DHCS, MHC conducts ongoing reviews of Provider/Practitioner performance. Among the elements to be reviewed are the following:

- Conducts an annual or more frequent geo-access audit to determine geographic, PCP and Specialist gaps in the network. The data provides information for contracting strategies
- MHC also conducts at least annual cultural, ethnic, racial and linguistic geo-access survey to assess availability of practitioners to meet the member's needs and determine network gaps. The data provides information for contracting strategies
- MHC conducts an annual telephonic survey to review the time it takes members to access emergency care, urgent care, non-urgent (routine) care, specialty care, initial health assessments, first prenatal visits, physical exams, and wellness checks in accordance with access standards disclosed in Section 5, Access to Care

Member Complaint and Grievance Indicators - Member concerns specific to the care and services of specific Providers/Practitioners are collected and acted upon by MHC's Member Services Department. Providers/Practitioners are engaged in the review of specific concerns and will be asked to assist in remedial endeavors, as indicated.

The outcomes and findings of the foregoing and other performance indicators are reviewed by MHC's Quality Improvement Department and by MHC's Quality Improvement Committee.

Quality Improvement Corrective Action Plans

When it is found that Providers/Practitioners or IPAs/Medical Groups do not meet the terms of their contracts, applicable policies and procedures, licensing and related requirements, and the provisions of this Manual, they will be notified in writing of deficiencies. Quality Improvement Corrective Action Plans (CAP) will be forwarded to Providers/Practitioners and will include corrective actions and dates by which corrective actions are to be achieved.

MHC representatives will work with and offer support to Providers/Practitioners to ensure the timely resolution of CAP requirements.

Providers/Practitioners who fail to respond to an initial corrective action plan by the date specified will be provided a second iteration of CAP requirements; may be assigned an extended action plan due date and/or sign a document stating they have completed the CAP.

Non-Compliance with Quality Improvement Corrective Actions
MHC's Quality Improvement and/or Provider Services Departments coordinates and assists the Provider/Practitioner with the development and implementation of the corrective action plan. Non-compliance with Quality Improvement corrective actions may result in any of the following:

- Contact by the MHC's Quality Improvement Department
- Conduct in-service/education
- Referral to the IPA or Medical Group for corrective action
- Implementation of Provider/Practitioner Compliance Department corrective action program which may result in the following sanctions:
  - The termination of new member enrollments
  - Moving current members to another IPA/Medical Group where the Provider/Practitioner is affiliated
  - Formal contract termination

Re-Audits

Re-audits are conducted to assure corrective actions have been effective in improving compliance with previously identified deficiencies.

DELEGATED IPAs AND MEDICAL GROUPS

MHC does not delegate any Quality Improvement Activities to any contracted Provider/Practitioner or IPA/Medical Group organization.

OVERSIGHT MONITORING OF UTILIZATION MANAGEMENT AND CREDENTIALING PROGRAMS FOR DELEGATED PROVIDERS

MHC may delegate responsibility for activities associated with utilization management (UM) and credentialing, to its IPAs/Medical Groups. Prior to approval of delegation, and at least annually thereafter, MHC conducts an onsite review of IPAs/Medical Groups requesting delegation. MHC uses delegation standards in compliance with NCQA, State and Federal Requirements. A member or designee of the delegation oversight team assigned to evaluate and oversee the IPAs/Medical Groups activities conducts the evaluation. Based on the audit scores and findings, if required thresholds and criteria are met, the appropriate peer review Committee may grant specific delegation functions to the IPA/Medical Group to perform. If approved for delegation "Acknowledgement Acceptance of Delegation" must be signed between MHC and the IPA/Medical Group. A "Delineation of Utilization Management Responsibilities" grid is included with the Acknowledgement and Acceptance of Delegation", outlining the delegated activities; MHC's Responsibilities; the Delegated IPA/Medical Group Responsibilities; the Frequency of Reporting; MHC's Process for Evaluating Performance; and, Corrective Actions if the IPA/Medical Group fails to meet responsibilities.

MHC reserves the right to request corrective action plans or revoke the delegation of these responsibilities when the Delegated group demonstrates noncompliance to NCQA State and Federal Requirements.

Complex Case Management services are not delegated to IPAs/Medical Groups. MHC's Medical Case Management Department retains sole responsibility for authorization and implementation of these services. IPAs/Medical Groups are required to refer known or potential cases to MHC Case Management. The referral may be made by a telephone or facsimile. This information can also be found in the Medical Management Section and in the Public Health Coordination and Case Management.

11.1 COMPLIANCE: PROVIDER EDUCATION

Provider education is implemented by Molina Healthcare of California (MHC) and its participating Medical Groups/Independent Physician Associations (IPAs) in counties where it is applicable. Goals, objectives, curricula, and implementation guidelines are established by MHC. Where applicable, participating Medical Groups/IPAs are responsible for conducting provider training and orientation, and MHC provides additional resources and opportunities to supplement such trainings.

All newly contracted providers are required to receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the contract and all applicable Federal and State statutes and regulations. MHC and applicable Medical Group/IPA are required to conduct training for all providers within ten (10) working days after the newly contracted provider is placed on active status. Provider training includes but is not limited to:

- Provider/Practitioner Manual (MHC and/or Health Net for LA County only)
- Federal and State statutes and regulations to ensure provider's full compliance and applicable policies and procedures
- Web Portal Training
- Prior Authorization
- Preventive Care Services
- Training on provider billing and reporting, including information prohibiting balance billing
- Encounters, claims submission, appeals and grievances, and compensation information
- Disability Awareness and Sensitivity Training regarding SPDs based on "Clinical Protocols and Practice Guidelines for Seniors and Persons with Disabilities/Chronic Conditions"
    - Providers will be trained on a continual basis regarding clinical protocols and evidenced-based practice guidelines for SPDs or chronic conditions. The training shall include an educational program for providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, information on MHC's website as well as other methods of educational outreach to providers
- Fraud, Waste, and Abuse
- Concepts in cultural competency. Training will discuss the practical applications of cultural competency, review cultural and linguistic contract requirements, discuss Molina's language access services and tips for working with interpreters, and go over cultural competency resources
    - Providers/Practitioners are trained on how to promote access and delivery of services in a culturally competent manner to all members. This includes those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. Providers/Practitioners must ensure that members have access to covered services that are delivered in a manner that meets their unique needs. For more information on promoting access and delivery of services in a culturally competent manner, please refer to the "Cultural and Linguistic Services" section of the manual
- Model of Care, Coordination of Care, Behavioral Health services, LTSS, community supports and other Medicare Medicaid Plan/Cal MediConnect program requirements and ensure access is provided
- LTSS, including but not limited to, Community Based Adult Services, In Home Supportive Services, Multi-Purpose Senior Services Program and Skilled nursing facility/subacute care services. Training will include information about how to identify LTSS needs, eligibility criteria, and how to appropriately refer for LTSS services
- Distribution of Members Rights and Responsibilities, including the right to full disclosure of health care information and the right to actively participate in health care decisions

MHC and applicable Medical Group/IPA are required to ensure ongoing training is conducted when deemed necessary.

Membership Panel Form

All IPAs and direct providers are required to notify MHC of changes made to Membership Panels within five (5) business days. Timely submission of this information is vital for maintaining an up-to-date provider directory and allows our members to accurately identify which providers, in our network, are accepting new patients. The Membership Panel Form enables IPAs and direct providers to feasibly modify their membership panels and inform MHC of those modifications.

IPAs and direct providers are requested to submit the Membership Panel form on the next page within five (5) business days when there is a change in regard to accepting new members. Providers affiliated to IPAs should submit the required information directly to their IPAs as appropriate. If a provider who is not accepting new members is contacted by a member or someone seeking to become a new member, the provider shall direct the member or potential member to MHC for additional assistance in finding a provider and to the Department of Managed Health Care to report any inaccuracy with the plan's directory.

Provider Name				
NPI				
Street Address				
City, State, Zip Code				
Phone Number				
IPA Affiliation/Group Name and/or Pay to Affiliation				
Accepting New Members?	Medi-Cal	Covered CA/ Marketplace	Medicare	Cal Medi-Connect
	Yes No	Yes No	Yes No	Yes No

Please mail or fax the completed form to one of the appropriate locations listed below. For providers affiliated with IPAs, please submit the required information directly to your IPA, who will submit the information to MHC.

Los Angeles
200 Oceangate, Suite 100
Long Beach, CA 90802
Attn: Provider Services
Fax: (855) 278-0312
Phone: (562) 499-6191

Riverside/San Bernardino
550 E. Hospitality Ln, Suite100
San Bernardino, CA 92408
Attn: Provider Services
Fax: (909) 890-4403
Phone: (800) 232-9998

San Diego
9275 Sky Park Ct, Suite
San Diego, CA 92123
Attn: Provider Services
Fax: (858) 503-1210
Phone: (858) 614-1580

Imperial
1607 W. Main St.
El Centro, CA 92243
Attn: Provider Services
Fax: (760) 679-5705
Phone: (760) 679-5680

Sacramento
2180 Harvard St., Suite
Sacramento, CA 95815
Attn: Provider Services
Fax: (916) 561-8559
Phone: (916) 561-8540

Name of individual completing this form: _____

Signature of individual completing this form: _____

Phone Number: _____

Date: _____ /_____ / _____

If you have any questions or concerns, please contact your Provider Services Representative.

11.2 COMPLIANCE: QUALITY IMPROVEMENT

QUALITY IMPROVEMENT PROGRAM

Purpose

The purpose of the Molina Healthcare of California (MHC) Quality Improvement Program is to establish methods for objectively and systematically evaluating and improving the quality of care and service provided to MHC members. MHC strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The MHC's Quality Improvement Program promotes a commitment to quality in every facet of the health plan's structure and processes. It relies on senior management oversight and accountability and integrates the activities of all health plan departments in meeting the program's goals and objectives. The Quality Improvement Program involves all key stakeholders, members, participating practitioners, providers and health plan staff, in the development, evaluation and planning of quality improvement activities.

The MHC's Quality Improvement Program incorporates a continuous, quality improvement methodology that focuses on the specific needs of its internal and external customers. It is organized to identify and analyze significant opportunities for improvement in delivery of health care and service, to develop improvement strategies, and to track systematically, if these strategies result in progress toward benchmarks or goals. The methodology includes pursuing our goals in a culturally competent manner.

The written Quality Improvement Program defines the goals, objectives, scope, structure, committees and functions of the program. The Quality Improvement Program is reviewed and updated annually and presented to the Quality Improvement Committee (QI Committee) and to the Board of Directors for approval.

Scope of the Quality Improvement Program

The MHC Quality Improvement Program encompasses the quality of acute, chronic, and preventive clinical care and service provided in both the inpatient and outpatient setting by hospitals and facilities, participating provider groups, primary care and specialty practitioners, and ancillary providers.

Its specific focus includes:

1. The continuity and coordination of care.
2. The over-and-under-utilization of services.
3. The access to and availability of routine, urgent and, emergency care.
4. The health status of MHC members of all products.
5. Provider and practitioner qualifications and performance.
6. The environmental, physical, and clinical safety of MHC members.
7. The implementation of preventive health and clinical practice guidelines.
8. Member and practitioner satisfaction.
9. The effectiveness of health plan services including member education and services, practitioner relations and services, credentialing, utilization and case management, claims adjudication, risk management, and pharmacy management.
10. The ethnic and linguistic appropriateness of care and service.
11. Behavioral health services as defined by DHCS.
12. Assessing the effectiveness of quality improvement activities

PROVIDER/PRACTITIONER REVIEW PROCESS

Provider/Practitioner Facility Site Review (FSR)

- Effective July 1, 2002 the State of California's Health and Human Services Agency mandated that all County Organized Health Systems (COHS), Geographic Managed Care (GMC) Plans, Primary Care Case Management (PCCM) Plans, and Two-Plan Model Plans use the Full Scope Site Review and Medical Record Review Evaluation Tool. For more details on FSR, please reference Section 11.0: Facility Site Review
- All primary care sites serving Medi-Cal managed care members must undergo an initial site review and subsequent periodic site review every three (3) years using the current DHCS approved facility site review survey tool. Managed care health plans may review sites more frequently per local collaborative decision or when determined necessary, based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues. For more details on FSR, please reference Section 11.0: Facility Site Review
- The Medi-Cal managed care health plans within the county have established systems and procedures for the coordination and consolidation of site audits for mutually shared PCP sites and facilities to avoid duplication and overlapping of FSR reviews. For more details on FSR, please reference Section 11.0: Facility Site Review
- All Primary Care Physicians must maintain an Exempted or Conditional pass on site review to participate in MHC provider network. The evaluation scores are based on standardized scoring mechanism established by DHCS. Please refer to the Credentialing section of the Provider Manual for expanded information about FSR requirements. For more details on FSR, please reference Section 11.0: Facility Site Review

Medical Record Review (MRR)

- The on-site practitioner/provider medical record review is a comprehensive evaluation of the medical records. MHC will provide information, suggestions and recommendations to assist practitioners/providers in achieving the standards. For more details on MRR, please reference Section 11.0: Facility Site Review
- All PCPs must complete and pass the medical record review at each practice location. Medical Record Reviews are conducted in conjunction with the Facility Site Review, prior to participating in MHC provider network and at least every three (3) years thereafter. For more details on MRR, please reference Section 11.0: Facility Site Review
- All Primary Care Physicians must maintain an Exempted or Conditional pass on medical record review to participate in MHC provider network. The evaluation scores are based on standardized scoring mechanism established by DHCS. Please refer to the Credentialing section of the Provider Manual for expanded information about MRR requirements. For more details on MRR, please reference Section 11.0: Facility Site Review

Physical Accessibility Review Survey (PARS)

- In accordance to the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) policy letter 11-013, managed care health plans are required to assess the level of physical accessibility of provider sites, including all primary care physicians, specialists and ancillary providers that serve a high volume of Seniors and Persons with Disabilities (SPD). The Physical Accessibility Review Survey (PARS) tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA). For more details on PARS, please reference Section 11.0: Facility Site Review
- Unlike the Facility Site Review and Medical Records Review, PARS is a survey and no corrective action is required. Please refer to the Credentialing section of the Provider Manual for expanded information about

PARS requirements. For more details on PARS, please reference Section 11.0: Facility Site Review

Child Health and Disability Prevention (CHDP) Reviews

- CHDP is a state preventive service program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services
- MHC provides health assessment, preventive health care and coordination of care to eligible Members through the CHDP program
- CHDP specific questions are incorporated into the Medical Record Review Tool. The CHDP review may be done concurrently with the medical record review
- CHDP requirements are detailed in the Medical Record Pediatric Review Guidelines

Comprehensive Perinatal Services Program (CPSP) Review

- The CPSP is designed to increase access to prenatal care and to improve pregnancy outcomes. The services of this program include health and nutrition education, psychosocial assessment, treatment planning, and periodic reassessment. CPSP must be offered to all MHC Medi-Cal Members, but participation is voluntary. Refusal of CPSP must be documented in the patient's obstetrical record

11.3 COMPLIANCE: FRAUD, WASTE, AND ABUSE

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, the Compliance department maintains a comprehensive plan, which addresses how Molina will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste, and abuse prevention and detection, along with the education of appropriate employees, vendors, providers and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission Statement

Molina regards health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina has therefore implemented a plan to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a Federal statute that covers fraud involving any Federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. Government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or,
- Acts in reckless disregard of the truth or falsity of the information in a claim

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act

The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protection rights as a whistleblowers

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections State that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole including:
- Employment reinstatement at the same level of seniority;
- Two times the amount of back pay plus interest;
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare will take steps to monitor Molina Healthcare of California contracted providers to ensure compliance with the law.

Anti-Kickback Statute – Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other Federal health care programs.

Stark Statute – Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to Medicare and Medicaid services provided only by physicians, rather than by all health care Providers.

Sarbanes-Oxley Act of 2002 – Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

Waste: Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.

Abuse: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically

necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

The types of questionable Provider schemes investigated by Molina include, but are not limited to the following:

- A physician knowingly and willfully referring a Member to health care facilities in which or with which the physician has a financial relationship. (Stark Law)
- Altering claims and/or medical record documentation in order to get a higher level of reimbursement
- Balance billing a Molina Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees
- Billing and providing for services to Members that are not medically necessary
- Billing for services, procedures and/or supplies that have not been rendered
- Billing under an invalid place of service in order to receive or maximize reimbursement
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider
- Concealing a Member's misuse of a Molina identification card
- Failing to report a Member's forgery or alteration of a prescription or other medical document
- False coding in order to receive or maximize reimbursement
- Inappropriate billing of modifiers in order to receive or maximize reimbursement
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients
- Not following incident to billing guidelines in order to receive or maximize reimbursement
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges
- Questionable prescribing practices
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code
- Underutilization, which means failing to provide services that are Medically Necessary
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more
- Using the adjustment payment process to generate fraudulent payments

Examples of Fraud, Waste, and Abuse by a Member

The types of questionable Member schemes investigated by Molina include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits
- Conspiracy to defraud Medicaid
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services
- Falsifying documentation in order to get services approved
- Forgery related to health care
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that he/she does not suffer from and the Member sells the medication to someone else

Review of Provider Claims and Claims System

Molina Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance Department.

The claims payment system utilizes system edits and flags to validate those elements of claims are billed in accordance with standardized billing practices; ensure that claims are processed accurately and ensure that payments reflect the service performed as authorized.

Molina performs auditing to ensure the accuracy of data input into the Claims system. The claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment Fraud, Waste, and Abuse Detection Activities

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

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

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

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at Law or equity. In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to Provider's records, all of the Claims for which Provider received payment from Molina is immediately due and owing. If Provider fails to provide all requested documentation for any Claim, the entire amount of the paid Claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Claim Auditing

Molina shall use established industry Claims adjudication and/or clinical practices, Commonwealth, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Molina's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon ourMolina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of claims that weMolina paid in error. The estimated proportion, or error rate, may be projected across all claims to determine the amount of overpayment.

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

Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

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

Provider Education

When Molina identifies through an audit or other means a situation with a provider (e.g. coding, billing) that is either inappropriate or deficient, Molina may determine that a provider/practitioner education visit is appropriate.

The Molina Provider Services Representative will inform the provider's office that an on-site meeting is required in order to educate the provider on certain issues identified as inappropriate or deficient.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached toll free at 1-866-606-3889 or you may use the service's website to make a report at any time at https://MolinaHealthcare.alertline.com

You may also report cases of fraud, waste or abuse to Molina's Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of California
Attn: Compliance
200 Oceangate, Suite 100
Long Beach, CA 90802

Remember to include the following information when reporting:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to the state at:
California Department of Health Care Services
Toll Free Phone: 1-800-822-6222

11.4 COMPLIANCE: HIPAA REQUIREMENTS & INFORMATION

HIPAA (The Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

Protecting the privacy of members' personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all Federal and State laws regarding the privacy and security of members' protected health information (PHI).

Provider Responsibilities

Molina expects that its contracted Providers will respect the privacy of Molina members (including Molina members who are not patients of the provider) and comply with all applicable laws and regulations regarding the privacy of patient and member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

Applicable Laws

Providers must understand all State and Federal health care privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that Providers/Practitioners must comply with. In general, most health care Providers are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
    - HIPAA
    - The Health Information Technology for Economic and Clinical Health Act (HITECH)
    - 42 C.F.R. Part 2
    - Medicare and Medicaid laws
    - The Affordable Care Act

2. State Medical Privacy Laws and Regulations
   Providers should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the State law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

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

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2]."
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
    - Quality improvement
    - Disease management;
    - Case management and care coordination;
    - Training Programs;
    - Accreditation, licensing, and credentialing

Importantly, this allows Providers/Practitioners to share PHI with MHC for our healthcare operations activities, such as HEDIS and quality improvement.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

[2]See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

Patient Rights

Patients are afforded various rights under HIPAA. Molina Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of Privacy Practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices

2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a healthcare Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions

3. **Requests for Confidential Communications**
   Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient

4. **Requests for Patient Access to PHI**
   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care

5. **Request to Amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set

6. **Request Accounting of PHI Disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003

HIPAA Security

Providers should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information—without the person's knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA Transactions and Code Sets

Molina requires the use of electronic transactions to streamline healthcare administrative activities. Molina Providers must submit claims and other transactions to Molina using electronic formats. Certain electronic

transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at: www.MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

1. Click on the tab titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions. For Claims with dates of service prior to October 1, 2015, ICD-9 coding must be used. For Claims with dates of service on or after October 1, 2015, Providers must use the ICD-10 code sets.

National Provider Identifier

Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days and should also be reported to Molina within thirty (30) days of the change. Provider must use its NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to MHC.

Additional Requirements for Delegated Providers

Providers that are delegated for claims and utilization management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for Copies of PHI

Molina does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management;
- Care Coordination and/or Complex Medical Care Management Services;
- Claims Review;
- Resolution of an Appeal and/Grievance;
- Anti-Fraud Program Review;
- Quality of Care Issues;

- Regulatory Audits;
- Risk Adjustment;
- Treatment, Payment and/or Operation Purposes; and
- Collection of HEDIS® medical records

Your Privacy

Dear Molina Healthcare of California Partner Plan, Inc. (Molina Healthcare) Member:

Your privacy is important to us. We respect and protect your privacy. Molina Healthcare uses and shares your information to provide you with health benefits. Molina Healthcare wants to let you know how your information is used or shared.

Your Protected Health Information

PHI stands for these words, *protected health information*. PHI means health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Does Molina Healthcare use or share our members' PHI?
- To provide for your treatment
- To pay for your health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To use or share PHI for other purposes as required or permitted by law.

Does Molina Healthcare need your written authorization (approval) to use or share your PHI?
Molina Healthcare needs your written approval to use or share your PHI for purposes not listed

What are your privacy rights?
- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have given your PHI

How does Molina Healthcare protect your PHI?
Molina Healthcare uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways Molina Healthcare protects PHI:
- Molina Healthcare has policies and rules to protect PHI
- Molina Healthcare limits who may see PHI. Only Molina Healthcare staff with a need to know PHI may use it
- Molina Healthcare staff is trained on how to protect and secure PHI
- Molina Healthcare staff must agree in writing to follow the rules and policies that protect and secure PHI Molina Healthcare secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords
-

Our Notice of Privacy Practices has more information about how we use and share our members' PHI. Our Notice of Privacy is in the following section and is on our web site at www.MolinaHealthcare.com. You may also get a copy of our Notice of Privacy by calling our Member Services Department at (888) 665-4681.

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF CALIFORNIA PARTNER PLAN, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

California Partner Plan, Inc. ("Molina" or "we") provides health care benefits to you through the Medi-Cal program. Molina uses and shares protected health information about you to provide your health care benefits. We use and share your information to carry out treatment, payment and health care operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private. We have policies in place to obey the law. The effective date of this notice is March 1, 2013.

PHI stands for these words, protected health information. PHI means health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

We use or share your PHI to provide you with healthcare benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment.

Molina may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes referrals between your doctors or other health care providers. For example, we may share information about your health condition with a specialist. This helps the specialist talk about your treatment with your doctor.

Payment.

Molina may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, your condition, your treatment, and supplies given may be written on the bill. For example, we may let a doctor know that you have our benefits. We would also tell the doctor the amount of the bill that we would pay.

For Health Care Operations.

Molina may use or share PHI about you to run our health plan. For example, we may use information from your claim to let you know about a health program that could help you. We may also use or share your PHI to solve member concerns. Your PHI may also be used, to see that claims are paid right.

Health care operations involve many daily business needs. It includes, but is not limited to, the following:

- Improving quality
- Actions in health programs to help members with certain conditions (such as asthma)
- Conducting or arranging for medical review
- Fraud and abuse programs
- Actions to help us obey laws
- Address member needs, including solving complaints and grievances

We will share your PHI with other companies ("business associates") that perform different kinds of activities for our health plan. We may also use your PHI to give you reminders about your appointments. We may use it PHI to give you information about other treatment, or other health-related benefits and services.

When can MHC use or share your PHI without getting written authorization (approval) from you?

The law allows or requires MHC to use and share your PHI for several other purposes including:

Required by law
We will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

Public Health
Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight
Your PHI may be used or shared with government agencies. They may need your PHI to check how our health plan is providing services.

Legal or Administrative Proceedings
Your PHI may be shared with a court, investigator or lawyer if it is about the operation of Medi-Cal. This may involve fraud or actions to recover money from others, when the Medi-Cal program has provided your health care benefits.

When does MHC need your written authorization (approval) to use or share your PHI?
MHC needs your written approval to use or share your PHI for purposes other than those listed in this notice. You may cancel a written approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

What are your health information rights?
You have the right to:

- **Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)**

You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to make your request in writing. You may use Molina's form to make your request

- **Request Confidential Communications of PHI**

You may ask MHC to give you your PHI in a certain way or at a certain place to help keep your PHI private. We will follow reasonable requests, if you tell us how sharing all or a part of that PHI could put your life at risk. You will need to make your request in writing. You may use MHC's form to make your request

- **Review and Copy Your PHI**

You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions as a MHC member. You will need to make your request in writing. You may use MHC's form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases we may deny the request
Important Note: We do not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.

- **Amend Your PHI**

You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a member. You will need to make your request in writing. You may use MHC's form to make your request. You may file a letter disagreeing with us if we deny the request

- **Receive an Accounting of PHI Disclosures (Sharing of your PHI)**

You may ask that we give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:

- for treatment, payment or health care operations;
- to persons about their own PHI;
- sharing done with your authorization;
- incident to a use or disclosure otherwise permitted or required under applicable law;
- as part of a limited data set in accordance with applicable law; or shared prior to April 14, 2003

We will charge a reasonable fee for each list if you ask for this list more than once in a 12-month period. You will need to make your request in writing. You may use MHC's form to make your request. You may make any of the requests listed above or may get a paper copy of this Notice. Please call our Director of Member Services at 1-888-665-4621.

Do I Complain?
If you believe that we have not protected your privacy and wish to complain, you may file a complaint (or grievance) by calling or writing us at:
Molina Healthcare of California Partner Plan, Inc. Member Services (888) 665-4621

We will not do anything against you for filing a complaint. Your care will not change in any way.

OR you may call, write or contact the agencies below:

Privacy Officer
c/o: Office of Legal Services
California Department of Health Care Services
P.O. Box 997413, MS 0011
Sacramento, CA 95899-7413 (916) 440-7700
Email: privacyofficer@dhcs.ca.gov

Secretary of the U.S. Department of Health and Human Services
Office for Civil Rights
U.S. Department of Health & Human Services
50 United Nations Plaza - Room 322
San Francisco, CA 94102
(415) 437-8310; (415) 437-8311 (TDD); (415) 437-8329 FAX

What are the duties of Molina?
MHC is required to:
- Keep your PHI private.
- Give you written information such as this on our duties and privacy practices about your PHI.
- Follow the terms of this Notice

This Notice is Subject to Change - Changing information practices and terms of this notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, a new notice will be sent to you by US Mail.

If you have any questions, please contact the following:
Member Services
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
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12.0 CREDENTIALING: FACILITY SITE REVIEW

The facility site review (FSR) is a comprehensive evaluation of the facility, administration and medical records to ensure conformance to the California Department of Health Care Services (DHCS) and regulatory agency standards. The review and certification of Primary Care Practitioner (PCP) sites are required for all health plans participating in the Medi-Cal managed care program (Title 22, CCR, Section 56230). The California statute requires that all PCP sites or facilities rendering services to Medi-Cal eligible patients must be certified and compliant with all applicable DHCS standards. Furthermore, facility site reviews are required as part of the credentialing process, according to the provision of Title 22, CCR, Section 53856.

A PCP is defined as a General Practitioner, an Internist, a Family Practitioner, Obstetrician/Gynecologist (OB/GYN) who meets the requirements for PCP, or a Pediatrician who, by contract, agrees to accept responsibility for primary medical care services.

Facility Site Review Process

Effective July 1, 2002 the State of California's Health and Human Services Agency mandated that all County Organized Health Systems (COHS), Geographic Managed Care (GMC) Plans, Primary Care Case Management (PCCM) Plans, and Two-Plan Model Plans use the Full Scope Site Review and Medical Record Review Evaluation Tool. This is found in Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004 and includes, but is not limited to, any relevant superseding policy letters.

In efforts to avoid duplication and overlapping of FSR reviews, the Medi-Cal managed care health plans within the county have established systems and procedures for the coordination and consolidation of site audits for mutually shared PCP sites and facilities. One (1) site review conducted by a participating collaborative Medi-Cal managed care health plan will be accepted by other Medi-Cal managed care health plans. This will establish **ONE** (1) certified FSR and MRR that the participating PCP site will need to pass and be eligible with all the Medi-Cal Health Plans in a given county.

Standardized DHCS Facility Site Review Tool is comprised of three (3) components:

- Attachment A: Facility Site Review Tool
- Attachment B: Medical Record Review Tool
- Attachment C: Physical Accessibility Review Survey

Initial Full Scope Review

All primary care sites serving Medi-Cal managed care members must undergo an initial site review with attainment of a minimum passing score of eighty percent (80%) on the site review and medical record review. The initial site review is the first onsite inspection of a site that has not previously had a full scope survey, or a PCP site that is returning to the Medi-Cal managed care program and has not had a full scope survey within the past three (3) years with a passing score. The initial full scope site review survey can be waived by a managed care health plan for a pre-contracted physician site if the physician has a documented proof of current full scope survey, conducted by another Medi-Cal managed care health plan within the past three (3) years. MHC follows the same procedures as for an initial site visit when a PCP relocates or opens a new site.

Subsequent Periodic Full Scope Site Review

After the initial full scope survey, the maximum time period before conducting the subsequent full scope site survey is three (3) years. Managed care health plans may review sites more frequently per local collaborative decision or when determined necessary, based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues.

Medical Record Review

The on-site practitioner/provider medical record review is a comprehensive evaluation of the medical records. Molina Healthcare of California (MHC) will provide information, suggestions and recommendations to assist practitioners/providers in achieving the standards. All PCPs must complete and pass the medical record review at each practice location. Medical Record Reviews are conducted in conjunction with the Facility Site Review, prior to participating in MHC provider network and at least every three (3) years thereafter. Ten (10) medical records are reviewed for each physician. Sites where documentation of patient care by multiple PCPs occurs in the same medical record will be reviewed as a "shared" medical record system. Shared medical records are those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of ten (10) records will be reviewed if two (2) to three (3) PCPs share records, twenty (20) records will be reviewed for four (4) to six (6) PCPs, and thirty (30) records will be reviewed for seven (7) or more PCPs.

Physical Accessibility Review Survey (PARS)

In accordance to the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) policy letter 12-006, managed care health plans are required to assess the level of physical accessibility of provider sites, including all primary care physicians, specialists, ancillary providers and Community-Based Adult Services (CBAS) that serve a high volume of Seniors and Persons with Disabilities (SPD). The PARS tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA). PARS consist of eighty-six (86) criteria that include twenty-nine (29) determined critical access elements. Based on the outcome of the PARS review, each site is designated as having either Basic Access or Limited Access, and medical equipment access. Basic Access demonstrates that a facility site provides access for members with disabilities to parking, exterior building, interior building, waiting/reception, restrooms, and examination rooms. Unlike the Facility Site Review and Medical Records Review, **PARS is an assessment and <u>no corrective action</u> is required**. For 2016, PARS will also be conducted for ancillary and CBAS providers.

SCORING

All Primary Care Physicians must maintain an Exempted or Conditional pass on site review and medical record review to participate in MHC provider network. The evaluation scores are based on standardized scoring mechanism established by DHCS.

Compliance & Corrective Action Plan (CAP)

Facility Site Review Score Threshold

<u>Exempted:</u> A performance score of ninety percent (90%) or above ***without deficiencies*** in Critical Elements, Pharmaceutical or Infection Control sections of the review tool.
A Corrective Action Plan is not required.

<u>Conditional:</u> A performance score of eighty to ninety percent (80% - 90%) ***or*** ninety percent (90%) and above with deficiencies in Critical Elements, Pharmaceutical or Infection Control sections of the review tool.

A Corrective Action Plan is required.

Not Pass: Below eighty percent (80%) performance score.

Medical Record Review Score Threshold

Exempted: A performance score of ninety to one hundred percent (90% to 100%); any section score of less than eighty percent (80%) will require a Corrective Action Plan for the entire medical records reviewed, regardless of the total score

Conditional: A performance score of eighty to eighty-nine percent (80% to 89%).
A Corrective Action Plan is required.

Not Pass: Below eighty percent (80%) performance score.

Physicians with an Exempted Pass Score

All reviewed sites that score ninety to one hundred percent (90% to 100%) on the facility site review survey ***without deficiencies*** in Critical Elements, Pharmaceutical or Infection Control sections of the review tool do not need to submit a CAP.

All reviewed sites that score ninety to one hundred percent (90% to 100%) and greater than eighty percent (80%) on each section scores of the medical record review survey do not need to submit a CAP. Any section score of less than eighty percent (80%) in the medical record review survey requires submission of completed CAP, regardless of the aggregated MRR score.

Physicians with a Conditional Pass Score

A score of eighty to eighty-nine percent (80% to 89%) or ninety percent (90%) and above with deficiencies in Critical Element, Pharmaceutical or Infection Control sections of the review tool must complete and submit a CAP.

- Critical Element CAP must be completed, verified and submitted within ten (10) business days from the date of the review
- CAP must be completed and submitted within thirty (30) calendar days from the date of the written CAP request

A score of eighty to eighty-nine percent (80% to 89%) of the medical record review survey must complete and submit a CAP. The CAP must be submitted within thirty (30) calendar days from the date of the written CAP request.

Physicians with a Not Pass Score

A score of seventy-nine percent (79%) or below and survey deficiencies not corrected within the established CAP timelines will not have new members assigned until all deficiencies are corrected and the CAP is closed. The CAP must be completed, submitted timely, fully accepted, and verified or a follow-up visit must be conducted for a focused review with a passing score.

In compliance to the Department of Health Care Services, Medi-Cal Managed Care Division Policy Letter 14-004, physicians and sites with Not Pass scores must be notified to all Medi-Cal Managed Care Health Plans in the county.

CAP Extension

No timeline extensions are allowed for Critical Element CAP completion. A physician may request a definitive, time-specific extension period that does not exceed one-hundred-twenty (120) calendar days from the date of the survey findings report and CAP notification. The request shall be submitted through a formal written explanation of the reason(s) for the extension.

Any extension beyond one-hundred-twenty (120) calendar days requires an approval from the Department of Health Care Services and agreed upon by the health plan.

NOTE: AN EXTENSION PERIOD BEYOND 120 CALENDAR DAYS TO COMPLETE CORRECTIONS REQUIRES THAT THE SITE BE RESURVEYED PRIOR TO CLOSING THE CAP IN TWELVE (12) MONTHS.

CAP Completion

Physicians or their designees can complete the CAP:

- Review and correct the identified deficiencies in Column Two (2) and Column Three (3) of the CAP form
- Review and implement the recommended corrective actions in Column Four (4) of the CAP form and provide appropriate attachments or documents that address the deficiencies
- Enter the date of completion or implementation of the corrective action in Column Five (5) of the CAP form
- Document specific comments on implemented activities to address and satisfy the corrective action(s) and document a responsible designee's initials in Column Six (6) of the CAP form
- Document the signature and the title of the physician or the designee who is responsible for completing the CAP in Column Seven (7) of the CAP form
- Upon implementation, completion and documentation of the entire corrective action items identified on the CAP form, submit the completed CAP form

CAP Submission

The physician, at his/her discretion, may involve any or all IPAs/Medical Groups or management companies with which the physician is contracted to assist in completion of the CAP.

The CAP must be submitted directly to the Site Reviewer of the health plan.

Identification of Deficiencies Subsequent to an Initial Site Visit

Any MHC Director or Manager shall refer concerns regarding member safety and/or quality of care issues to appropriate Department(s) for necessary follow-up activities.

Member complaints related to physical office site(s) are referred to appropriate MHC Department(s) for subsequent investigation that may include performing an unannounced onsite facility review and follow-up of any identified corrective actions.

DEPARTMENT OF HEALTH CARE SERVICES (DHCS) REVIEW OF MOLINA HEALTHCARE'S PERFORMANCE OF FACILITY SITE REVIEWS

Review Process

An oversight audit of MHC and contracted physicians and facilities will be conducted by the DHCS.

- These visits may be conducted with or without prior notification from the DHCS

If a prior notification is given, the sites selected by the DHCS for oversight reviews will be contacted to arrange a visit schedule by either the DHCS auditor or MHC.

MHC will provide any necessary assistance required by the DHCS in conducting facility oversight evaluations.

Requirements and Guidelines for Facility Site

Complete and comprehensive requirements, standards, and guidelines are found in ***Facility Site Review Tool*** and ***Facility Site Review Guideline***.

Please visit MHC website at: www.MolinaHealthcare.com to review these documents.

Requirements and Guidelines for Medical Record Documentation (applies to both adults and children)
Complete and comprehensive requirements, standards, and guidelines are found in ***Medical Record Review Tool*** and ***Medical Record Review Guideline***.

Please visit MHC website at: www.MolinaHealthcare.com to review these documents.

Information Available to Providers on MHC Website

In efforts to assist our providers, there are many resources and topics that are relevant to Facility Site Review and Medical Records Review processes and guidelines. Please visit MHC website to access these materials and information:

- Facility Site Review Tool and Guidelines
- Medical Record Review Tool and Guidelines
- Interim Review of Critical Elements at 18 months
- FSR Attachment C: Physical Accessibility Review Survey (PARS)
- Frequently used facility forms and log sheets
- Frequently used Medical Record forms and documentations
- Preventive Health Guidelines
- Staying Healthy Assessment forms
- Clinical Practice Guidelines

12.1 CREDENTIALING: CREDENTIALING & RECREDENTIALING

The purpose of the Credentialing Program is to strive to assure that the Molina network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Molina provider services representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer Providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA©). In accordance with those standards, Molina Members will not be referred and/or assigned to you until the credentialing process has been completed.

Non-Discriminatory Credentialing and Recredentialing

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

Type of Practitioners Credentialed & Recredentialed

Practitioners and groups of practitioners with whom Molina contracts must be credentialed prior to the contract being implemented.

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral healthcare practitioners who are licensed, certified or registered by the state to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- *Nurse Practitioners
- Occupational Therapists

- Optometrists
- Oral Surgeons.
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- **Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioner

HIV/AIDS Specialist

Molina requires Practitioners to submit a complete, signed and dated HIV/AIDS Specialist form to identify appropriately qualified specialists who meet the definition of an HIV/AIDS specialist under California Code of Regulations Section 1374.16 of the Act.

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the Molina network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Practitioners who do not meet the criteria. Molina may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined that such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any Provider to a hearing or any other rights of review.

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

- Application - Provider must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within one-hundred-twenty (120) days. Application must include all required attachments
- License, Certification or Registration - Provider must hold current and valid unrestricted license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine practitioners are required to be licensed in the state where they are located and the State the member is located
- DEA or CDS Certificate - Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every

State where the Provider provides care to Molina Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number. If a Practitioner does not have a DEA or CDS because it has been revoked, restricted or relinquished due to disciplinary reasons, the Practitioner is not eligible to participate in the Molina network

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

- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, it would also be required that the Practitioner providing the supervision and/or oversight be contracted and credentialed with Molina
- **Work History** – Provider must supply most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the Practitioner must clarify the gap verbally or in writing. The organization will document a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing
- **Malpractice History** – Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application
- **Professional Liability Insurance** – Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Molina will also verify all licenses, certifications and registrations in every State where the Practitioner has practiced. At the time of initial application, the Practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent
- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioner must not be currently sanctioned, excluded, expelled or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner
- **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business
- **Professional Liability Insurance** – Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the

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

Practitioners activities on Molina's behalf. Practitioners maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance

- **Inability to Perform** – Practitioner must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner
- **Lack of Present Illegal Drug Use** – Practitioner must disclose if they are currently using any illegal drugs/substances
- **Criminal Convictions** – Practitioners must disclose if they have ever had any criminal convictions. Practitioners must not have been convicted of a felony or pled guilty to a felony for a health care related crime including but not limited to health care fraud, patient abuse and the unlawful manufacturing, distribution or dispensing of a controlled substance
- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing
- **NPI** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS)

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

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

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

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

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available
- The Practitioner's response must be sent to Molina Healthcare, Inc., Attention Kari Hough, CPCS, Credentialing Director, at PO Box 2470, Spokane, WA 99210

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the

primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

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

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

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

The Practitioner must notify the Credentialing department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

The only items in the file that may be copied by the Practitioner are documents, which the practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

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

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Molina Medical Director within two (2) weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than sixty (60) calendar days from the decision. Notification of recredentialing approvals are not required.

Recredentialing

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

Excluded Practitioner Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.
Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive

notice. Molina and its Subcontractors certify that neither it nor its Member/Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions

Molina monitors the following agencies for Provider sanctions and exclusions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality is identified. If a Molina Provider is found to be sanctioned or excluded, the Provider's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs
- State Medicaid Exclusions - Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent)
- Medicare Exclusion Database (MED) - Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List
- National Practitioner Database - Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles
- System for Award Management (SAM) – Monitor for Providers sanctioned with SAM

Molina also monitors the following for all Provider types between the recredentialing cycles:

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

Provider Appeal Rights

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

13.0 DELEGATION

This section contains information specific to Molina's delegation criteria and oversight process. Molina may delegate certain administrative responsibilities upon meeting all of Molina's delegation criteria. Molina is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted entities. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

Delegation Criteria

An entity may request Credentialing, Utilization Management or Claims delegation from Molina through Molina's Delegation Oversight Director/Manager or through their Contract Manager. Molina will request a potential delegate to submit policies and procedures for review and will schedule a time for an onsite pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation of the function.

Sanction Monitoring

All Delegates are required to have processes to screen staff and employees at all levels against Federal and State exclusion lists. Screening must be done prior to the employee/staff's hire date and occur monthly thereafter. Molina will include a Sanction Monitoring pre-assessment audit with all other pre-assessment audits, any time a function(s) is/are being considered for delegation.

Sanction Monitoring functions may be delegated to entities that meet Molina criteria. To be delegated for sanction monitoring functions, potential delegates must at minimum:

- Pass Molina's sanction monitoring pre-assessment, which is based on OIG standards
- Demonstrate that employees and staff are screened against Office of Inspector General (OIG) and System for Award Management (SAM) sanction lists prior to hire dates, and monthly thereafter
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina
- Agree to Molina's contract terms and conditions for sanction monitoring delegates
- Submit timely and complete Sanction Monitoring delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact
- Comply with all applicable accreditation and regulatory standards and applicable Federal and State Laws
- When staff or employees are identified as having a positive sanction, provide Molina with notification according to Contractual Agreements of the findings and action(s) being taken to ensure sanctioned staff is not providing services to Molina Members
- Provide a 90-day advance notification to MHC of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate and participate when applicable, in Health Plan, legal and regulatory inquiries and audits

Credentialing

Credentialing functions may be delegated to entities that meet National Committee for Quality Assurance© (NCQA) criteria for credentialing functions.

To be delegated for credentialing functions, potential delegates must at minimum:

- Pass Molina's credentialing pre-assessment, which is based on NCQA credentialing standards, contract requirements and state and federal regulatory requirements
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of practitioners included in delegation
- Have an ongoing monitoring process in place that screens all practitioners included in delegation against OIG and SAM, and exclusion lists a minimum of every thirty (30) days
- Have internal controls and quality monitoring of work performed by Credentialing staff
- Correct deficiencies within Molina established timeframes when issues of non-compliance are identified by Molina or a state or federal regulatory agency
- Agree to Molina's contract terms and conditions for credentialing delegates
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact
- Comply with all applicable accreditation and regulatory standards and applicable Federal and State Laws
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members
- Provide a ninety (90) day advance notification to MHC of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate and participate when applicable, in Health Plan, legal and regulatory inquiries and audits

Note: If the Provider is an NCQA© Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modification to the audit depends on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA© accredited or certified in Credentialing functions, or demonstrate an ability to meet all Health Plan, NCQA©, and State and Federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and recredentialing files, and a process to implement corrective action if issues of non-compliance are identified.

Utilization Management

Utilization Management (UM) functions may be delegated to entities that meet National Committee for Quality Assurance© (NCQA) criteria, regulatory and Molina established standards for utilization management functions and processes.

To be delegated for utilization management functions, potential delegates must at minimum:

- Pass Molina's Utilization Management pre-assessment, which is based on regulatory, NCQA UM and Molina established standards and state and federal regulatory requirements

- Have a multi-disciplinary Utilization Management Committee who is responsible for oversight of the UM program, review and approval of UM policies and procedures and ensuring compliance of the UM processes and decisions
- Have a full time Medical Director responsible for the UM program and holds an unrestricted license to practice medicine in California
- Have internal controls and quality monitoring of work performed by the UM staff
- Correct deficiencies within Molina established timeframes when issues of non-compliance are identified by Molina or a state or federal regulatory agency
- Agree to and cooperate with Molina's contract terms and conditions for utilization management delegates.
- Submit timely and complete Utilization Management delegation reports in a format and frequency determined by MHC
- Comply with all applicable accreditation and regulatory standards and applicable Federal and State Laws.
- Provide a 90-day advance notification to MHC of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process
    - In a timely and appropriate manner, respond, cooperate and participate when applicable, in Health Plan, legal and regulatory inquiries and audits.
    - Comply with contractual, regulatory and legal requirements for member and provider notification of utilization management decisions
    - Prohibit the use of verbal denials and other intangible methods of documenting physician review unless otherwise allowed by regulation or law

Claims

Claims functions may be delegated to entities that demonstrate the ability to meet regulatory and Health Plan requirements for Claims functions. To be delegated for Claims functions, potential delegates must at minimum:

- Pass Molina's Claims pre-assessment, which is based on state and federal laws and regulatory and Molina established standards
- Have internal controls and quality monitoring of work performed by Claims staff
- Correct deficiencies within Molina established timeframes when issues of non-compliance are identified by Molina or a state or federal regulatory agency
- Agree to Molina's contract terms and conditions for Claims delegates
- Submit timely and complete Claims delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact
- Comply with all regulatory standards and applicable Federal and State Laws
- Have systems enabled to accurately and timely adjudicate professional and facility claims, including but not limited to the appropriate application of interest penalties, edits, audit trail, fee schedule, provider contracting status, denial codes, payment codes, pend codes and accumulators
- Provide a 90-day advance notification to MHC of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate and participate when applicable, in Health Plan, legal and regulatory inquiries and audits

Oversight Monitoring of Delegated Functions

Prior to approval of delegation, and at least annually thereafter, MHC conducts an onsite review of IPAs/Medical Groups requesting delegation. MHC uses delegation standards and practices in compliance with NCQA, State and Federal Requirements. A member or designee of the Delegation Oversight team assigned to

evaluate and oversee the IPAs/Medical Groups activities conducts the audit. Based on the audit scores and findings, if required thresholds and criteria are met, the appropriate Committee may approve specific delegation of functions to the IPA/Medical Group to perform. Once approved for delegation, an "Acknowledgement Acceptance of Delegation" must be signed between MHC and the IPA/Medical Group. For delegation of utilization management, a "Delineation of Utilization Management Responsibilities" grid is included with the Acknowledgement and Acceptance of Delegation", outlining the delegated activities; MHC's Responsibilities; the Delegated IPA/Medical Group Responsibilities; the Frequency of Reporting; MHC's Process for Evaluating Performance; and, Corrective Actions if the IPA/Medical Group fails to meet its responsibilities. Adhoc audits may be conducted at the discretion of the Health Plan.

MHC reserves the right to request corrective action plans or revoke the delegation of these responsibilities when the Delegated group demonstrates noncompliance to NCQA, contractual, State and Federal Requirements.

Delegates must comply with all applicable State and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters (APLs) and Policy Letters.

Complex Case Management services are not delegated to IPAs/Medical Groups. MHC's Medical Case Management Department retains sole responsibility for authorization and implementation of these services. IPAs/Medical Groups are required to refer known or potential cases to MHC Case Management. The referral may be made by a telephone or facsimile. This information can also be found in the Medical Management Section and in the Public Health Coordination and Case Management.

14.0 RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

Risk Adjustment is a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Molina members and prepares for resources that may be needed in the future.

Why is Risk Adjustment Important?

- Allows Molina to focus on quality and efficiency
- Enables Molina to recognize and address current and potential health conditions early
- Identifies members for Case Management referral
- Ensures accurate payment for the acuity levels of Molina members
- Risk Adjustment allows Molina to have the resources to deliver the highest quality of care to Molina members

Your Role as a Provider

As a Provider your documentation in a member's medical record is critical to a Member's quality of care .

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

- Be compliant with CMS correct coding initiative
- Use the correct ICD-10 code by coding the condition to the highest level of specificity
- Only submit codes for diagnoses confirmed during a face to face visit with the Member
- Contain a treatment plan
- Be clear and concise
- Contain the Member's name and date of service
- Have the physician's signature and credentials

Contact Information

For questions about Molina's Risk Adjustment programs, please contact our team at:
RiskAdjustment.Programs@MolinaHealthcare.com

15.0 PROPOSITION 56: DIRECT & DELEGATED ENTITIES OR SUBCONTRACTORS

Proposition 56

How to File a Provider Grievance

Providers may initiate a grievance related to directed, supplemental and/or incentive-based payments by contacting the Provider Services Team and/or submitting by fax or mail. The following documentation is required to review and process a Provider grievance:

- Payment Cover Letter, Invoice Summary or a Letter of Explanation
    - If providing the letter of explanation, please be sure to include the provider tax identification number (TIN) or the national provider identifier (NPI)
- Documented reason for provider grievance related to payment discrepancy

Fax 562-499-0633

- Must include provider's fax number to receive the resolution of the dispute via fax
- Must include applicable supporting documents to justify grievance, if applicable

Provider Grievances and supporting documentation (via paper) should be submitted to:

Molina Healthcare of California
P.O. Box 22722
Long Beach, CA 90801
Attn: Provider Grievance and Appeals Unit

Please email mhcprovideredcomm@molinahealthcare.com to receive corresponding claim details electronically.

IPA Reporting Requirements to MHC
MHC is required to ensure that delegated entities distribute Prop 56 payments to providers in an accurate and timely manner.

Instructions: If you receive a Prop 56 Distribution Summary form with the requested information, complete and return the Prop 56 Payment Distribution Summary form to Prop56_Payment_Depo@MolinaHealthCare.Com with the following columns completed for each provider paid, no later than 30 calendar days from the date of receipt.

Evidence of Payment:

- Check Date
- Paid Amount
- Check No.

Evidence of Payment		
Check Date	Paid Amount	Check No.

Please maintain all records of provider payment consistent with regulatory record retention standards (CMS Final Rule, Title 42 Section 422.504). MHC may request payment evidence as part of the monitoring and audit activities.

16.0 HEALTH HOMES PROGRAM

The Molina Health Homes Program (HHP) is designed to serve eligible Medi-Cal beneficiaries with multiple chronic conditions and high utilization rates who may benefit from enhanced care management and coordination. The Health Homes Program offers a coordination of physical health, behavioral health, and community-based long-term services and supports (LTSS). These services are provided to eligible beneficiaries by a Community Based – Care Management Entity (CB-CME).
The Community-Based Care Management Entity: Each member has a Community-Based Care Management Entity (CB-CME) that serves as their provider of the Health Homes Program. Molina assigns members to a CB-CME, but members may choose another one if they prefer. In most cases, the CB-CME will be a primary care provider that serves a high number of HHP-eligible members. If the CB-CME is not the member's assigned primary care provider, the CB-CME must maintain a strong connection to the primary care provider to ensure their participation in the development and implementation of the Health Action Plan. **The CB-CME will encourage members to visit their doctor and may arrange transportation or accompany members to the doctors at the member's request. The CB-CME may also ask for medical information, for example blood pressure information, which is part of the program reporting requirements.**

The Health Action Plan: Once enrolled in the Health Homes Program, a member will receive a call from their CB-CME to assess their health needs, goals, and current providers. The member will be assigned a care coordinator who will work with them to make a plan for getting the health care and community services they need, The Health Action Plan or HAP guides the member's services and care, and is based on the member's health status, needs, preferences, and goals regarding: physical and mental health, substance use disorders, community-based long-term services and supports, including housing, palliative care, and trauma-informed care needs.

CB-CMEs will conduct a Health Risk Assessment (HRA) and complete the HAP within 90 days of the member opting into the Health Homes Program. Members are reassessed and the HAP modified at a minimum of every six months or when the member's condition changes. CB-CMEs will also conduct a new HRA within 45 days of Health Homes members experiencing a change in Medi-Cal status to SPD.

Core Services: The Health Homes Program includes the following six core services which can be provided in-person where the member seeks care or lives, or at any location that is accessible. Services can also be provided by phone or other communication methods that work for the member.

Comprehensive Care Management

- Comprehensive care management includes identifying individuals who would benefit from a Health Home, assessing members' medical and non-medical needs, developing member-centered care plans, and assigning roles in member care
- Members and/or caregivers should be actively involved in the development of the care plan, which should reflect the health goals and values of the member

Care Coordination

- Care coordination is carried out by a dedicated staff member who helps members and providers follow the care plan. A care coordinator should help members set and keep appointments, adhere to medication plans, and communicate with providers and family members

- Care coordinators or care managers also ensure effective cooperation and communication among providers

Health Promotion

- Health promotion is prevention-focused education and support for the member and family, and it should be specific to the member's chronic conditions and risk factors
- Health promotion should have a strong emphasis on member empowerment and self-management of chronic conditions

Transitional Care

- Comprehensive transitional care involves coordination and follow-up among providers, caregivers, and the member when the member leaves an inpatient facility or is transferred
- To prevent unnecessary re-admissions, the member's care coordinator should be in close contact with the member and their providers during such transitions

Individual and Family Supports

- Individual and family support services focuses on clear, effective, and culturally and linguistically appropriate communication among providers, the member, and the member's family or caregivers
- It also connects members and caregivers with peer supports, including support groups, self-care programs, and peer specialists

Referral to Community / Social Supports

- Referral to community and social support services helps members to obtain and maintain the non-medical resources they need to lead healthy lives
- Health Homes should refer members to resources such as long-term services and supports, disability benefits, nutrition assistance, education, housing, and legal services

To be eligible for the Health Homes Program, members must meet both of the following requirements

Multiple Chronic Condition	High Acuity
1) **Member meets at least one category below:** ❑ At least two of the following: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic kidney disease, chronic liver disease, dementia, or substance use disorders. ❑ Hypertension (high blood pressure) and one of the following: chronic obstructive pulmonary disease, diabetes, coronary artery disease, or chronic or congestive heart failure. ❑ One of the following: major depression disorders, bipolar disorder, or psychotic disorders (including schizophrenia).	2) **Member meets at least one category below:** ❑ Has three or more of the HHP-eligible chronic conditions. ❑ Has stayed in the hospital within the last year. ❑ Has visited the emergency department three or more times in the last year. ❑ Has chronic homelessness.

❑ Asthma.	

How to enroll a member to the Health Homes Program: Molina welcomes all provider referrals. Referral forms are available by emailing **Health_Homes_Program@MolinaHealthCare.Com .** Members may also self-refer by calling Member Service at: **(888) 665-4621 (TTY/TDD: 711).**

17.0 DEFINITIONS

- **Abuse -** provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

- **Aid to Families with Dependent Children (AFDC) -** A program offered by the State of California that provides cash grants, food coupons, and medical benefits for low income families

- **Alcohol Misuse Screening and Counseling (AMSC)** - Screening and Behavioral Counseling Interventions in Primary Care, also known as Alcohol Misuse Screening and Counseling (AMSC), services for MCP members ages 18 and older who misuse alcohol. This APL also provides guidance to MHC to ensure compliance with the Medicaid Managed Care for Mental Health Parity requirements included in the Final Rule (CMS-2333-F) issued by the Centers for Medicare and Medicaid Services (CMS) on March 30, 2016

- **All Plan Letter (APL)** - document that has been dated, numbered, and issued by DHCS that provides clarification of Contractor's obligations pursuant to this Contract, and may include instructions to Contractor regarding implementation of mandated changes in State or federal statutes or regulations, or pursuant to judicial interpretation

- **American Indian** – a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes membership in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native

- **American Indian Health Programs** – Facilities operated with funds from the Indian Health Service IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population within a defined geographic area, per Title 22, Section 55000

- **Appeal -** a review by Contractor of an adverse benefit determination, which includes one of the following actions: A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; B. A reduction, suspension, or termination of a previously authorized service; C. A denial, in whole or in part, of payment for a service; D. Failure to provide services in a timely manner; or Failure to act within the timeframes provided in 42 CFR 438.408(b)

- **Authorization –** Approval of requested, medically necessary services obtained by Providers/Practitioners for designated service before the service is rendered. Used interchangeably with Preauthorization or Prior Authorization

- **Auxiliary Aids** - supports that allow disabled Members to receive and understand information and include, but are not limited to, the use of TTY/TDDY, Braille, large font of at least 18-point, and American Sign Language interpreters

- **Beneficiary Identification Card (BIC) -** A permanent plastic card issued by the State to recipients of entitlement programs which can be used by contractors to verify health plan eligibility. Files are updated monthly, as well as daily in special circumstances

- **California Children Services (CCS) -** The public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions

- **Capitation Payment** - a regularly scheduled payment made by DHCS to Contractor on behalf of each Member enrolled under this Contract and based on the actuarially sound capitation rate for the provision of Covered Services, and made regardless of whether a Member receives services during the period covered by the payment

- **Child Health and Disability Prevention Program (CHDP) -** Preventive well-child screening program for eligible beneficiaries under 21 years of age provided in accordance with the provisions of Title 17, CCR, Section 6800 et seq. Includes the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, and the Prenatal Guidance Program

- **Central Issuance Division (CID) -** A unit at DHCS that reports for eligibility data systems

- **Claim -** A request for payment for the provision of Covered Services prepared on a CMS 1500 form, UB04, PM160 for CFDP Services or successor

- **Clean Claims** - A claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim

- **Community Based Adult Services (CBAS) -** CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. CBAS services include: an individual assessment; professional nursing services; physical, occupational and speech therapies; mental health services; therapeutic activities; social services; personal care; a meal; nutritional counseling; and transportation to and from the participant's residence and the CBAS center

- **Comprehensive Medical Case Management Services** - services provided by a Primary Care Provider in collaboration with the Contractor to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees an Eligible Beneficiary. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs

- **Comprehensive Perinatal Services Program (CPSP) -** A State sponsored program developed to provide quality health care for women during and surrounding pregnancy by encouraging evaluation in obstetrical, nutritional, social, and educational spheres to assess and address high risk conditions

- **Contracting Provider** - A physician, nurse, technician, hospital, home health agency, nursing home, or any other individual or institution contracted to provide medical services to health plan members

- **Conviction** (or convicted) - A judgment of conviction has been entered by a Federal, State or local court regardless of whether an appeal from that judgment is pending (42CFR 455.2). This definition also includes the definition of the term "convicted" in Welfare and instructions Code Section 14043.1(f)

- **Covered Services -** Those healthcare services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Plan product which covers the Member

- **Credentialing -** The verification of applicable licenses, certifications, and experience to assure that Provider/Practitioner status be extended only to professional, competent Providers/Practitioners who continuously meet the qualifications, standards, and requirements established by MHC

- **Department of Managed Health Care (DMHC) -** The State department responsible for administering the Knox Keene Act of 1975. Knox Keene established the DMHC as the legally designated State regulatory agency for managed health care organizations

- **Department of Health Care Services (DHCS) -** The State department solely responsible for administration of the Medi-Cal, CPSP, CCS, CHDP, and other health related programs

- **Department of Mental Health (DMH) -** The State agency that sets policy and administers the delivery of community based public mental health services statewide

- **Direct PCP -** A Primary Care Practitioner (PCP) that holds a contract with MHC

- **Durable Medical Equipment (DME) -** Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home

- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program -** The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medi-Cal. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services

- **Eligible Beneficiary -** Any Medi-Cal beneficiary who resides in the contractor's service area and who falls into one or more of the following categories (with a specific aid code): Aid to Families with Dependent Children, Medically Needy Family, Public Assistance Aged, Medically Needy Aged, Public Assistance Blind, Medically Needy Blind, Public Assistance Disabled, Medically Needy Disabled, Medically Indigent Child, Medically Indigent Adult, and Refugees

- **Emergency Medical Transportation** - ambulance services for an emergency medical condition, and includes emergency air transportation

- **Emergency Services -** Covered Services necessary to evaluate or stabilize a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in: (a) placement of the

Member's health (or the health of the Member's unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114

- **Encounter Data -** the administrative information that describes health care interactions between patients Members and providers relating to the receipt of any item(s) or service(s) by a Member under this contract and subject to the standards of 42 CFR 438.242 and 438.818

- **Enrollment Form -** See "Medi-Cal Choice Form."

- **Evidence of Coverage (EOC) -** The document provided to plan members describing access, benefits, and exclusions of plan services

- **Excluded Service** - a service that is covered by the Medi-Cal program but is not covered by Contractor because it is carved out of Contractor's contractual obligations for the provision of Covered Services

- **External Quality Review** - an analysis and evaluation by the EQRO of aggregated information on quality, timeliness and Access to the Covered Services that Contractor or its subcontractors furnish to Members

- **External Quality Review Organization (EQRO)** - a Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in a state's Medicaid managed care plans, meets the competence and independence requirements set forth in 42 CFR 438.354, and is contracted with DHCS to perform External Quality Reviews and other related activities per 42 CFR 438.358

- **Fee-For-Service (FFS) -** A method of charging based upon billing for a specific number of units of services rendered to an Eligible Beneficiary. Fee-For-Service is the traditional method of reimbursement used by Providers/Practitioners, and payment almost always occurs retrospectively

- **File and Use -** a submission to DHCS that does not need review and approval prior to use or implementation, but which DHCS can require edits as determined. **Fraud -** an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

- **Geographic Managed Care (GMC) -** A program which requires Medi-Cal beneficiaries who reside in a designated geographic area to enroll in one of two or more competing health plans under contract with the DHCS

- **Healthcare Effectiveness Data and Information Set (HEDIS) -** A widely used set of performance measures in the managed care industry developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS is used for quality improvement activities, health management systems, Provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report card for managed care organizations

- **Health Care Options (HCO) (formerly Health Choice) -** The State Department of Health Care Services' program that provides Medi-Cal beneficiaries with information about healthcare benefits and with enrollment and disenrollment assistance

- **Health Insurance Portability and Accountability Act (HIPAA) -** The Federal Law that requires all healthcare providers to protect the privacy and security of members protected health information (PHI)

- **Health Maintenance Organization (HMO) -** An organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined, periodic, and fixed prepayment

- **In-Home Support Services (IHSS)** - services provided for members in accordance with the requirements set forth in Welfare and Institutions W & I Code Section 14186.1(c)(1), and Article 7 of the W & I Code, commencing with Section 12300 of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956

- **Independent Practice Association (IPA) -** A legal entity, the members of which are independent Providers/Practitioners who contract with the IPA for the sole purpose of having the IPA contract with one or more HMOs

- **Long-Term Care (LTC)** - care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days

- **Managed Long Term Services and Support (MLTSS)** - services and supports provided by Contractor to Members who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. In this Contract, MLTSS includes CBAS, LTC, IHSS, MSSP, and SNFs, to the extent Contractor is at-risk for covering SNF services

- **Management Information System (MIS) -** System of organizing and aggregating data so as to enable rapid access to data. Often used to refer to computer systems used to pay claims, maintain Provider/Practitioner databases, and generate reports

- **Maximus -** The vendor contracted by the Department of Health Care Services that provides Medi-Cal beneficiaries with information about selecting a health plan. Maximus is also responsible for the mailing of enrollment packets to new Medi-Cal beneficiaries

- **Medi-Cal Choice Form (**A.K.A. Medi-Cal Enrollment Form) **-** This form is distributed by Health Care Options (HCO) and is used for Medi-Cal Beneficiaries to select their health plan and primary care practitioner. This form may also be used for beneficiaries to disenroll from a health plan

- **Medi-Cal Managed Care Health Plan** - a managed care health plan that contracts with the Department of Health Care Services for provision or arrangement of Medi-Cal benefits and services

- **Medical Group -** A medical group practice that holds a contract with a health plan

- **Medical Records -** A confidential document containing written documentation related to the provision of physical, social, and mental health services to a member.

- **Medically Necessary -** Those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Plan policy.

- **Medically Necessary or Medical Necessity** - reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain

- **Medical Eligibility Data System (MEDS) Tape -** The computerized data vehicle (tape) DHCS sends monthly to MHC for member eligibility determination. This tape must be processed by MHC to extract the data regarding eligibility prior to printing updated eligibility rosters and calculating capitation payments

- **Member -** Any enrolled individual on whose behalf periodic payments are made to MHC and is eligible to receive covered services

- **Member Appeal** - A request by the member or designated representative for the plan to review an Adverse Benefit Determination that involves the delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit

- **Member Complaint/Grievance -** an expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, (as identified within the definition of Member Appeal), and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision.

- **Member Evaluation Tool (MET)** – Member Evaluation Tool (MET) means the information collected from a Health Information Form (HIF), a high-level initial assessment completed by beneficiaries Members at the time of enrollment by through which they may self-identify disabilities, acute and chronic health conditions, and transitional service needs. For newly enrolled SPD beneficiaries Contractor must use the MET as part of the health risk assessment process

- **Multipurpose Senior Service Program (MSSP)** - the Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver

- **NCQA -** National Committee for Quality Assurance

- **National Provider Identifier (NPI) -** The National Provider Identifier is a 10-digit number assigned by Centers for Medicare & Medicaid Services (CMS) to all covered providers of healthcare who transmit information electronically (HIPAA Transactions). The NPI is intended to improve efficiency and effectiveness of the healthcare system by reducing the number of identifiers associated with providers and facilities (i.e. UPIN, BCBS, Medicaid, other payer specific numbers). As of May 23, 2007, any healthcare provider who transmits heath information electronically is required to have an NPI. All HIPAA transactions must use an NPI as the sole means to identify a provider of service. The NPI number last indefinitely and does not change regardless of job or location changes. There are 2 types of NPI: Individual: Physicians, physician assistants, nurse practitioners, chiropractors. Organization: Hospitals, clinics, labs (May have multiple NPIs for each subpart – urgent care, lab, pharmacy, etc.)

- **Network** - the number of PCPs, Specialists, hospitals, pharmacy, ancillary providers, facilities, and any other Providers that subcontract with Contractor for the delivery of Medi-Cal Covered Services

- **Network Provider -** a Provider that subcontracts with Contractor for the delivery of Medi-Cal Covered Services

- **Newborn Child -** A newborn child is covered for the month of birth and the following month when delivered by the mother during her membership with the Plan

- **Notice of Action (NOA)** – a former letter informing a beneficiary of an A

- **Out-of-Network Provider** - a Provider that does not participate in Contractor's Network

- **Outpatient Mental Health Services** - outpatient services that Contractor will provide for Members with mild to moderate mental health conditions requiring services not covered by the county mental health plan as specialty mental health services, including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements

- **Overpayment** - any payment made by Contractor to a Network Provider to which the Network Provider is not entitled to under Title XIX of the Act or any payment to Contractor by DHCS to which Contractor is not entitled to under Title XIX of the Act

- **Plan -** Molina Healthcare of California Partner Plan, Inc

- **Potential Quality of Care (PQOC) -** Process to identify opportunities to evaluate, review, and address a potential quality of care issue

- **Practitioner -** The professional who provides health care services. Practitioners are required to be licensed as defined by law. A practitioner that participates in MHC's network may be referred to as a "participating or contracted" practitioner

- **Prescription Drug** - a drug and/or medication that can only be accessed by prescription

- **Preventive Care -** Health care designed to prevent disease and/or its consequences. There are three (3) levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary,

such as disease screening programs, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after disease has occurred

- **Primary Care -** A basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and/or midlevel practitioners. This type of care emphasizes caring for the member's general health needs as opposed to focusing on specific needs involving the use of specialists

- **Primary Care Practitioner (PCP) -** Physician that provides primary care services (including family practice, general practice, internal medicine, and pediatrics) and manages routine health care needs. A woman may select an obstetrician/gynecologist as her PCP

- **Prior Authorization** – Approval of requested, medically necessary services obtained by a Provider/Practitioner before the service is rendered. Used interchangeably with Preauthorization or Authorization

- **Protected Health Information (PHI) -** Under the US Health Insurance Portability and Accountability Act (HIPPA), is any information about health status, provision of health care, or payment for health care that can be linked to an individual; including any part of a patient's medical record or payment history

- **Provider -** any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. Examples of providers include hospitals and home health agencies. NCQA uses the term "practitioner" to refer to the professionals who provide health care services. However, NCQA recognizes that a "provider directory" generally includes both providers and practitioners, and the inclusive definition is the more common usage of the term "provider." A provider that participates in MHC's network may be referred to as a "participating or contracted" provider

- **Provider/Practitioner Grievance or Complaint -** an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a Provider. DHCS considers Provider complaints and appeals the same as a Provider Grievance

- **Quality Improvement (QI) -** A formal set of activities to assure the quality of clinical and nonclinical services provided as outlined in MHC's Quality Improvement Program. Quality Improvement includes assessment and improvement actions taken to remedy any deficiencies identified through the assessment process. The Providers/Practitioners agree to abide by and participate in MHC's QI Program

- **Readmission:** An episode when a patient who had been discharged from a hospital is admitted again within a specified time interval

- **Referral -** The practice of sending a patient to another Provider/Practitioner for services or consultation which the referring Provider/Practitioner is not prepared or qualified to provide

- **Related Condition:** A condition that has a same or similar diagnosis or is a preventable complication of a condition that required treatment in the original hospital admission

- **Safety-Net Provider –**any Provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the Provider. Examples of safety-net providers Safety-Net Providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; Rural and American Indian Health Service Programs; disproportionate share hospitals; and public, university, rural, and children's hospitals

- **Sensitive Services -** The following services are considered sensitive: sexual assault, confidential HIV testing and counseling, abortion services, drug or alcohol abuse for children of 12 years of age or older, pregnancy, family planning, and sexually transmitted diseases (drug or alcohol use disorders and sexually transmitted diseases are designated by the Director of DHCS for children 12 years of age or older)

- **Service Area -** The geographic area that the Plan services as designated and approved by the California Department of Managed Health Care

- **Short-Doyle Medi-Cal Mental Health Services (SD/MC) -** Program operated by the State Department of Mental Health to provide necessary community mental health services to Med-iCal beneficiaries that meet Short-Doyle eligibility criteria as defined in Title 22, CCR, Section 51341. Services include crisis intervention, crisis stabilization, inpatient hospital services, crisis residential treatment case management, adult residential treatment, day treatment intensive, rehabilitation, outpatient therapy, medication, and support services

- **Skilled Nursing Care** - Care or treatment that may only be performed by licensed nurses in a Skilled Nursing Facility or in a member's place of residence

- **Specialist -** a Physician who has completed advanced education and clinical training in a specific area of medicine or surgery

- **Specialty Mental Health Service –** A.) Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services; B.) Psychiatric inpatient hospital services; C.) Targeted Case Management; D.) Psychiatrist services; E.) Psychologist services; and F.) EPSDT supplemental Specialty Mental Health Services

- **Subcontractor** - an individual or entity who has a Subcontract with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract with DHCS

- **Utilization Management (UM) –** The appropriateness and medical necessity of health care services, procedures, and facilities according to nationally recognized evidence-based criteria or guidelines

- **Waste -** Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program

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