Molina Healthcare of California

Molina Dual Options Medicare-Medicaid Program

Los Angeles, Riverside, San Bernardino and San Diego Counties

MolinaHealthcare.com

MOLINA HEALTHCARE

Your Extended Family.

Dear Provider,

Welcome to Molina Healthcare of California (Molina) and thank you for your participation in the delivery of quality health care services to Molina Dual Options (Medicare-Medicaid Program) Members. Enclosed is your Molina Dual Options (Medicare-Medicaid Program) Provider Manual.

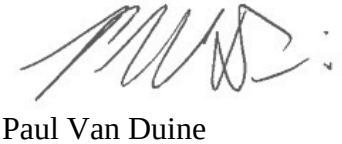
This Provider Manual shall serve as a supplement as referenced thereto and incorporated therein, to your Molina Healthcare of California Services Agreement. In the event of any conflict between this Provider Manual and the Provider Manual distributed with reference to Molina Medicaid or Molina Medicare Members, this Provider Manual shall take precedence over matters concerning the management and care of Molina Dual Options Plan Members.

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 Medicare-Medicaid 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. – 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 health care services to our Molina Dual Options (Medicare-Medicaid Program) Members.

Sincerely,



Paul Van Duine
Vice President of Network Management & Operations
Molina Healthcare of California
200 Oceangate, Suite 100, Long Beach, CA 90802
Tel: (562) 435-3666 Fax: (562) 951-8313

Table of Contents

1. Introduction

Molina Dual Options (MMP) is the brand name of Molina Healthcare of California's Medicare-Medicaid Program.

Molina is licensed and approved by the Centers for Medicare & Medicaid Services (CMS) to operate in the following states: California, Florida, Illinois, Michigan, New Mexico, Ohio, Texas, Utah and Washington.

Molina Dual Options MMP)

Dual Options (MMP) is the name of Molina's Medicare-Medicaid Program. The Dual Options plan was designed for Members who are dual eligible: individuals who are eligible for both Medicare and full Medicaid in order to provide quality healthcare coverage and service with little out-of-pocket costs. Dual Options (MMP) embraces Molina's longstanding mission to serve those who are the most in need and traditionally have faced barriers to quality health care.

Please contact the Provider Services Department, Monday through Friday, from 8:00 a.m. – 8:00 p.m., toll free at (855) 322-4075 with questions regarding this program.

Use of this Manual

From time to time, this manual will be revised as policies or regulatory requirements change. All changes and updates will be updated and posted to the Molina Medicare-Medicaid website. The Provider manual is accessible electronically on the Provider website at www.MolinaHealthcare.com. All contracted Providers can also request to receive a hard copy or CD version of the Provider Manual annually, which will be made available by contacting the Provider Services Department, Monday through Friday, from 8:00 a.m. to 8:00 p.m., toll free at (855) 322-4075.

This manual contains samples of the forms needed to fulfill your obligations under your Molina contract. If you are already using forms that accomplish the same goals, you may not need to modify them.

2. Background and Overview of Molina Healthcare (Molina)

Molina Healthcare, headquartered in Long Beach, California, is a national managed care company focused on providing health care services to people who receive benefits through government-sponsored programs. Molina is a health plan driven by the belief that each person deserves access to affordable, quality health care.

The company began in 1980 as a provider organization with a network of primary care clinics in California. As the need to more effectively manage and deliver health care services to low-income populations grew, Molina has grown to be a health plan serving millions of Members across the country.

The Benefit of Experience

By focusing exclusively on serving low-income families and individuals who receive health care benefits through government-sponsored programs, Molina has developed strong relationships with Members, Providers and government agencies within each regional market that it serves. Molina's ability to deliver quality care, establish and maintain Provider networks, and administer services efficiently has enabled it to compete successfully for government contracts.

Quality

Molina is committed to quality and has made accreditation a strategic goal for each health plan. Year after year, Molina health plans have received accreditation from the National Committee for Quality Assurance© (NCQA). The NCQA accreditation process sets the industry standard for quality in health plan operations.

Flexible Care Delivery Systems

Molina has constructed its systems for health care delivery to be readily adaptable to different markets and changing conditions. Health care services are arranged through contracts with Providers that include independent Providers, medical groups, hospitals and ancillary Providers. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates and diagnostic-related groups (DRG).

Cultural and Linguistic Expertise

National census data shows that the United States' population is becoming increasingly diverse. Molina has over thirty-five (35) years of history developing targeted health care programs for a culturally diverse membership, and is well-positioned to successfully serve these growing populations by:

- Contracting with a diverse network of community-oriented Providers who have the capabilities to address the linguistic and cultural needs of Members;
- Educating employees about the differing needs among Members; and,
- Developing Member education material in a variety of media and languages and ensure the literacy level is appropriate for our target audience.

3. Contact Information for Providers Molina Dual Options Plan

Molina Dual Options Plan (Medicare-Medicaid Program)
Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802

24 HOUR NURSE ADVICE LINE FOR MOLINA DUAL OPTIONS PLAN		
Services available in English and in Spanish.	English Telephone	(888) 275-8750
	Spanish Telephone	(866) 648-3537
	Hearing Impaired (TTY/TDD)	711
CLAIMS AND CLAIMS APPEALS		
Mailing Address: Molina Dual Options Claims P.O. Box 22702 Long Beach, CA 90801 **Note: For contested claims, please resubmit a hard copy claim with the information*	Telephone	(888) 322-4075
COMPLIANCE/ANTI-FRAUD HOTLINE		
Confidential Compliance Officer Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802	Telephone	(866) 606-3889
	Email	https://MolinaHealthcare.alertline.com
CREDENTIALING		
Molina Dual Options Plan of California Credentialing Department 200 Oceangate, Suite 100 Long Beach CA 90802	Telephone	(800) 526-8196, Ext. 120117
	Fax	(888) 665-4629
QUALITY IMPROVEMENT		
Molina Dual Options Plan Quality Improvement Department 200 Oceangate, Suite 100 Long Beach CA 90802	Telephone	(888)-562-5442
	Fax	(562) 499-6185

INPATIENT/CONTINUED STAY REVIEW		
Molina Dual Options Plan Utilization Management	Telephone	(844) 557-8434 24/7 including Afterhours, Weekends, Holidays
	Fax	(866) 553-9263 Medicare
PRIOR AUTHORIZATION (PRE-SERVICE)		
Molina Dual Options Plan Utilization Management	Telephone	(855) 322-4075 Option 4, Option 4, Option 2, Option 2, Option 2 24/7
	Fax	(844) 251-1451
EMERGENCY DEPARTMENT SUPPORT UNIT (EDSU)		
Molina Dual Options Plan Emergency Department Support Unit	Telephone	EDSU 24/7: (844) 966-5462
	Fax	Fax ED notification to: (877) 665-4625
CASE MANAGEMENT		
Referrals to case management can be made via phone, fax or email.	Telephone	(888) 562-5442 x 127604 Monday-Friday 8:30-5:30pm
	Fax	(562) 499-6105
	Email	MHCCaseManagement@MolinaHealthcare.com
COUNTY MENTAL HEALTH		
Los Angeles	**Los Angeles County Department of Mental Health** 550 South Vermont Avenue Los Angeles, CA 90020 (800) 854-7771	
Riverside	**Riverside University Health System – Behavioral Health** CARES (Community Access, Referral, Evaluation, and Support) Line (800) 706-7500 phone (800) 915-5512 TTY	
San Bernardino	**San Bernardino County Behavioral Health** 303 E. Vanderbilt Way San Bernardino, CA 92415 Member Services: 24/7 Access & Referral Helpline: 1 (888) 743-1478 (909) 386-8256 TTY	
San Diego	**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	

EMERGENCY DEPARTMENT SUPPORT UNIT (EDSU)		
Molina Dual Options Plan 200 Oceangate, Suite 100 Long Beach, CA 90802	Telephone	EDSU 24/7: (844) 966-5462
	Fax	Fax ED notification to: (877) 665-4625
DENTAL		
Avesis Third Party Administrators 10324 S Dolfield Road Owings Mill, MD 21117	Telephone	Toll Free Phone (800) 327-4462
VISION		
March Vision Care 6701 Center Drive W, Suite 790 Los Angeles, CA 90045	Telephone	Toll Free Phone (844) 366-2724

4. Eligibility and Enrollment in Molina Dual Options Plan

Members who wish to enroll in Molina's Dual Options Plan, must meet the following eligibility criteria:

- Age twenty-one (21) and older at the time of enrollment;
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits;
- Eligible for full Medicaid (Medi-Cal);
  - Individuals enrolled in the Multipurpose Senior Services Program (MSSP)
  - Individuals who meet the share of cost provisions-
    - Nursing facility residents with a share of cost;
    - MSSP enrollees with a share of cost;
    - IHSS recipients who met their share of cost on the first day of the month, in the fifth and fourth months prior to their effective passive enrollment date for the Demonstration
- Individuals eligible for full Medicaid (Medi-Cal) per the spousal impoverishment rule codified at section 1924 of the Social Security Act
  - For those Enrollees who are nursing facility level of care, subacute facility level of care, or intermediate care facility level of care and reside or could reside outside of a hospital or nursing facility, a Medi-Cal eligibility determination shall be made "as if" the beneficiary were in a long-term care facility. Specifically, the spousal impoverishment rule codified section 1924 of the Act will apply to Enrollees. The terms "intermediate care facility level of care" and "nursing facility level of care" and "subacute facility level of care" shall have the same meaning as defined in Title 22 of the California Code of Regulations sections 51120, 51124, and 52224.5.
- Reside in the applicable duals demonstration counties: Los Angeles, Riverside, and San Bernardino, and San Diego.
  - Up to 200,000 individuals in Los Angeles may be enrolled in the Demonstration.
- Molina's Dual Options Plan will accept all Members that meet the above criteria and elect Molina's Dual Options Plan during appropriate enrollment periods.

Further, the enrollment table below summarizes eligibility for the Demonstration, including populations that will be excluded from enrollment.

Population	**Eligibility (CA Welfare and Institutions Code Section 14132.275)**
Everyone eligible for the demonstration must be a full-benefit dual eligible	Included
Beneficiaries in rural zip codes excluded from managed care	Excluded
Beneficiaries with other Health Coverage – Two-Plan/Geographic Managed Care	Excluded

Population	Eligibility (CA Welfare and Institutions Code Section 14132.275)
(GMC) county	
Beneficiaries with other Health Coverage – County Organized Health System (COHS) county	Excluded
Beneficiaries under age twenty-one (21)	Excluded
Beneficiaries in the following 1915(c) Waivers: Nursing Facility/Acute Hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver.	Excluded
ICF-DD Residents	Excluded
Resident in one of the Veterans' Homes of California	Excluded
Beneficiaries with ESRD – previous diagnosis (excluding San Mateo and Orange counties)	Excluded
Beneficiaries with ESRD – subsequent diagnosis post-enrollment	Included
Beneficiaries with a Share of Cost – in skilled nursing facility, MSSP, or IHSS and continuously certified to meet share of cost as detailed in Appendix 7, section III.D.ix	Included
Beneficiaries with a Share of Cost – in community and not continuously certified	Excluded

Individuals that may enroll but may not be passively enrolled include:

- Individuals residing in the following rural zip codes in San Bernardino County in which only one Cal MediConnect Plan operates: 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92326, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, and 92398;
- Individuals enrolled in Medicare Advantage in 2014;
- Individuals in one of the following programs may enroll only after they have disenrolled from the program:
    - Individuals enrolled in the following 1915(c) waivers: Nursing Facility/Acute hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver; and
    - Individuals enrolled in Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation.

A. Enrollment/Disenrollment Information

All Members of Molina's Dual Options Plan are full benefit dual eligible (e.g., they receive both Medicare and Medicaid). Centers for Medicare & Medicaid Services (CMS) rules state that these

Members may enroll or disenroll from Participating Plans and transfers between Participating Plans on a month-to-month basis any time during the year; and will be effective on the first day of the month following the request to do so.

B. Prospective and Existing Member Toll-Free Telephone Numbers

Existing Members may call our Member Services Department Monday-Friday 8:00 a.m. to 8:00 p.m. local time at (855) 665-4627. For TTY/TDD users call 711.

C. Effective Date of Coverage

The effective date of coverage for Members will be the first day of the month following the acceptance of enrollment received through the CMS TRR file. An enrollment cannot be effective prior to the date the Member or their legal representative signed the enrollment form or completed the enrollment election. During the applicable enrollment periods, if Molina's Dual Options Plan receives a confirmed enrollment through the CMS TRR file process, Molina's Dual Options Plan ensures that the effective date is the first day of the following month.

D. Disenrollment

Staff of Molina's Dual Options Plan may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare MMP Member to disenroll except when the Member has:

1. A change in residence (includes incarceration – see below) makes the individual ineligible to remain enrolled in the MMP;
2. The Member loses entitlement to either Medicare Part A or Part B;
3. The Member loses Medicaid eligibility;
4. The Member dies;
5. The Member materially misrepresents information to the MMP regarding reimbursement for third-party coverage.

When Members permanently move out of Molina's service area or leave Molina's service area for over six (6) consecutive months, they must disenroll from Molina's Dual Options Plan. There are a number of ways that the Molina's Enrollment Accounting department may be informed that the Member has relocated:

- Out-of-area notification will be received from DHCS and forwarded to CMS on the monthly membership report;
- Through the CMS DTRR file (confirms that the Member has disenrolled);
- The Member may call to advise Molina's Dual Options Plan that they have relocated; and
- Molina will direct them to DHCS for formal notification; and/or,
- Other means of notification may be made through the Claims Department, if out-of-area claims are received with a residential address other than the one on file; Molina will inform DHCS so they can reach out to the Member directly to begin the disenrollment process. (Molina's Dual Options Plan does not offer a visitor/traveler program to Members).

Molina's Dual Options Plan will refer the Member to DHCS (or their designated vendor, Health Care Options) to process disenrollment of Members from the health plan only as allowed by CMS regulations. Molina's Dual Options Plan may request that a Member be disenrolled under the following circumstances:

- Member requests disenrollment;
- Member enrolls in another plan;
- Member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan Members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Other reasons for the disenrollment may be one of the following (where Molina will notify DHCS to begin the disenrollment process):

- Member abuses the enrollment card by allowing others to use it to fraudulently obtain services;
- Member leaves the service area and directly notifies Molina's Dual Options Plan of the permanent change of residence;
- Member has not permanently moved but has been out of the service area for six (6) months or more;
- Member loses entitlement to Medicare Part A or Part B benefits;
- Member loses Medicaid eligibility;
- Molina's Dual Options Plan loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina's Dual Options Plan will send CMS approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely, before the termination of the plan; and/or
- Molina's Dual Options Plan discontinues offering services in specific service areas where the Member resides.

In all circumstances except death, (where DHCS delegates) Molina's Dual Options Plan will provide a written notice to the Member with an explanation of the reason for the disenrollment; otherwise DHCS (or it's designated enrollment vendor) will provide a written notice. All notices will be in compliance with CMS regulations and will be approved by CMS. Each notice will include the process for filing a grievance.

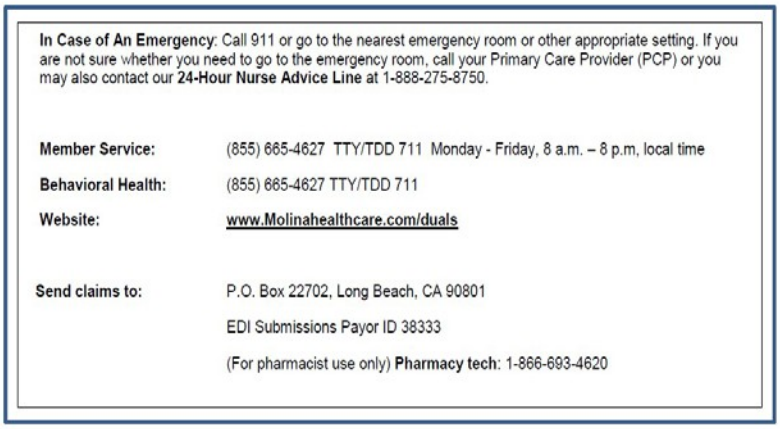
In the event of death, a verification of disenrollment will be sent to the deceased Member's estate.

Provider and or Members may contact our Member Services Department at (855) 665-4627, to discuss enrollment and disenrollment processes and options.

E. Member Identification Card

Front Member Identification Card

Back of Member Identification Card



F. Verifying Eligibility

Verification of membership and eligibility status is necessary to ensure payment for healthcare services being rendered by the Provider to the Member. Molina's Dual Options strongly encourages Providers to verify eligibility at every visit and especially prior to providing services that require authorization. Possession of the ID card does not guarantee Member eligibility or coverage. It is the responsibility of the Practitioner/Provider to verify the eligibility of the cardholder.

MMP Eligible and Cost-Share: Molina's Dual Options Plan allows only Members who are entitled to full Medicare and Medicaid benefits to enroll in California plans. These Members have $0 copays for Medicare covered services.

To verify eligibility, Providers may use 1-855-665-4627 or visit www.MolinaHealthcare.com.

5. Benefit Overview

A. Questions about Molina Dual Options Plan Benefits

If there are questions as to whether a service is covered or requires prior authorization, please contact **Molina Member Services Department Monday through Friday 8:00 a.m. to 8:00 p.m. toll free at** (855) 665-4627 **or 711 for persons with hearing impairments (TTY/TDD).**

B. Links to Summaries of Benefits

The following web link provides the 2019 Summary **of Benefits for** the Molina Dual Options (MMP) plan in California: http://www.MolinaHealthcare.com/members/ca/en-US/mem/duals/resources/info/pages/benefits.aspx

C. Links to Evidence of Coverage

Detailed information about benefits and services can be found in the 2019 **Evidence of Coverage booklets** sent to each Molina Member.

The following web link provides the **Evidence of Coverage** for the 2019 Molina Medicare Dual Options (MMP) plan in California: http://www.MolinaHealthcare.com/members/ca/en-US/mem/duals/resources/info/pages/eoc.aspx

D. Medical and Non-Medical Transportation

Member transportation is covered by Molina and coordinated through Secure Transportation for all Molina Dual Options (MMP) Plan Members. Detailed information about benefits can be found in the 2019 **Evidence of Coverage booklets** sent to each Molina Member.

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).
- 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 (NMT) is available if the 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.

Quality

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers in administering the Molina Medicare-Medicaid Quality Improvement Program. You can contact the Molina Quality Department **toll free at 888-562-5442 or fax (562) 499-6185.**

The address for mail requests is:
Molina Dual Options Plan - (CA Health Plan)
Quality Improvement Department
200 Oceangate, Suite 100
Long Beach, CA 90802

This Provider Manual contains excerpts from the Molina Quality Improvement Program (QIP). For a complete copy, please contact your Provider Services Representative or call the telephone number above.

Molina has established a QIP 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 Members.

Molina does not delegate Quality Improvement activities to Medical Groups/Independent Practice Association (IPAs). However, Molina requires contracted Medical Groups/IPAs and other delegated entities to comply with the following core elements and standards of care. In addition, Medical Groups/IPA must:

- Have a Quality Improvement Plan in place;
- Comply with and participate in Molina Medicare-Medicaid'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 QI personnel for site and medical record keeping and documentation practices.

A. Patient Safety Program

Molina Dual Options Plan's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Dual Options Plan 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 national recognized quality index ratings for facilities including adverse events, critical incidents, 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) and Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General report to Congress regarding the incidence of "never events" among Medicare beneficiaries, the payment for services in connection with such events, and the Centers for Medicare & Medicaid Services (CMS) processes to identify events and deny payment.

B. 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".

C. 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 accurate and 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.

1. 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 Improvement and HIPPA 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.

2. 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.
- 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.
- A signed document stating with whom protected health information may be shared.

3. 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 medical information for facilitation of medical care.

4. 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 the External Quality Review Organization upon 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 ten (10) years.
- An established and functional data recovery procedure in the event of data loss.

5. 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 or 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 and enrollment information.
- Medical Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Ensure that precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Educate and train all staff on handling and maintaining protected healthcare information.

Additional information on medical records is available from your local Molina Dual Options Plan Quality Improvement Department **toll free at (888)-562-5442.** See also the Compliance section of this Provider Manual regarding HIPAA.

D. Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted Primary Care Providers (PCP) (adult and pediatric) and participating specialists (to include OB/GYN, behavioral health Providers, and high volume and high impact specialists). Providers are required to conform to the 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. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to Members.

1. Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Dual Options Plan Members in the timeframes noted:

Primary Care Practitioner (PCP)	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Emergency Care	Immediate
Urgent Care not requiring prior authorization	<Within forty-eight (48) hours of the request
Urgent Care requiring prior authorization	Within ninety-six (96) hours of the request
Preventive Care Appointment	<Within twenty (20) business days of the request
Routine Care/Non-Urgent Care	<Within ten (10) business days of the request
After Hours Care	**After-Hours Instruction/Standards**
After hours emergency instruction	Members who call Member Services are instructed if this is an emergency, please hang up and dial 911
After-Hours Care	Available by telephone twenty-four (24) hours/seven (7) days
Timely physician response to after hour phone calls/pages	Within ≤ thirty (30) minutes
Specialty Care Provider (SCP)	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Routine Care/Non-Urgent Care	<Within fifteen (15) working days of the request
Urgent Care	<Within forty-eight (48) hours of request

Mental/Behavioral Health	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Non-life Threatening Emergency Care	Within ≤ six (6) hours of request
Urgent Care	Within ≤ forty-eight (48) hours of request
Urgent Care Requiring Prior Authorization	Within ≤ ninety-six (96 hours of request
Routine Care/Non-Urgent Care	Within ≤ ten (10) business days of request
Ancillary Services	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Non-urgent appointment for ancillary services	Within fifteen (15) business days of the request

Additional information on appointment access standards is available from your local Molina Dual Options Plan QI Department **toll free at (888)-562-5442.**

2. Office Wait Time

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

3. After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour 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.

4. Appointment Scheduling

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

a. 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;

b. 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. If a second appointment is missed, the Provider is to notify the **Molina Provider Services Department toll free at (855) 322-4075.**

c. 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;

d. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-bound Members and Members requiring language translation;

e. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to, immunizations and mammograms; and,

f. 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.

5. 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 Resources tab on the www.Molinahealthcare.com website or from your local Molina Quality Department **toll free at (888) 562-5442.**

6. 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.

Additional information on access to care is available under the Resources tab on the www.MolinaHealthcare.com website or is available from your local Molina Quality Department **toll free at (888) 562-5442.**

E. Quality of Provider Office Sites

Molina has a process to ensure that the offices of all Providers meet its office-site and medical record keeping practices standards. Molina continually monitors Member complaints/grievances for all office sites to determine the need of an office site visit and will conduct office site visits within sixty (60) calendar days. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This form includes the Office Site Review Guidelines and the Medical Record Keeping Practice Guidelines (as outlined above under “Medical Record Keeping Practices”) and the thresholds for acceptable performance against the criteria. This includes an assessment of:

- Physical Accessibility
- Physical Appearance
- Adequacy of Waiting and Examining Room Space
- Adequacy of Medical/Treatment Record Keeping

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

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

During the site visit, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not

limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Adequacy of Medical Record-Keeping Practices

During the site-visit, Molina discusses office documentation practices with the Provider's staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and includes how the practice ensures confidentiality of records. Molina assesses one (1) medical/treatment record for the areas described under "Medical Record Keeping Practices." To ensure Member confidentiality, Molina reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

F. Monitoring Office Site Review Guidelines and Compliance Standards

Provider office sites must demonstrate an overall eighty percent (80%) compliance with the "Office Site Review Guidelines" listed above. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

Administration & Confidentiality of Facilities

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

- 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.
- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
- Handicapped parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (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.

Improvement Plans/Corrective Action Plans

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

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

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

Additional reviews are conducted at the office at six (6) month intervals until compliance is achieved. At each follow-up visit a full assessment is done to ensure the office meets performance standards. The information and any response made by the Provider is included in the Providers permanent credentials file and reported to the Credentialing Committee on the watch status report. If compliance is not attained at follow-up visits, an updated CAP will be required.

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

G. Advance Directives (Patient Self-Determination Act)

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

Advance Directives are a written choice for health care. There are three (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 Care Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are state specific to meet State regulations.

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

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 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.

H. Quality Improvement Activities and Programs

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

Health Management

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

Care Management

Molina's Care Management Programs involve 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 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. For additional information please see the Care Management section under 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 appropriate 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 Management
- Sickle Cell Disease

The adopted Clinical Practice Guidelines are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality Improvement, Provider Services, Health Education and Member and Provider Contact Center. 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 your local Molina QI Department toll free at (888)-562-5442.

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 up to 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 old 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 an annual basis, Preventive Health Guidelines are distributed to Providers via the Molina website, 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.

I. Measurement of Clinical and Service Quality

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

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

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

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

Molina's most recent results can be obtained from your local Molina Quality Department staff **toll free at (800) 526-8196, Ext. 126137**, or fax (562) 499-6185 or by visiting our website at www.MolinaHealthcare.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the NCQA© HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from 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-up, medication use and cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina'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 services they receive. CAHPS® examines specific areas, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care, and Getting Needed Prescription Drugs. The CAHPS® survey is administered annually in the spring to randomly selected Members by an approved NCQA©-certified vendor.

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

Medicare Health Outcomes Survey (HOS)

The HOS measures Medicare Members' physical and mental health status over a two (2)-year period and categorizes the two (2)- year change scores as better, same, or worse than expected. The goal of the HOS is to gather valid, reliable, clinically meaningful data that can be used to target quality improvement activities and resources, monitor health plan performance and reward top performing health plans. Additionally, the HOS is used to inform beneficiaries of their healthcare choices, advance the science of functional health outcomes measurement, and for quality improvement interventions and strategies.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results

from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider Network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

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

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

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 go to www.MolinaHealthcare.com and click on Providers. There is a variety of resources, including:

- HEDIS® CPT/ICD-10 code sheet.
- A current list of HEDIS® & CAHPS® Star Ratings measures.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

7. Healthcare Services

Utilization Management

Introduction

Molina provides care management services to Members using processes designed to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Molina utilizes an integrated case management model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Elements of the Molina utilization management program include Pre-service review and Organization Determination/ Authorization management that includes pre-admission, admission and inpatient review, Medical Necessity review, and restrictions on the use of non-network Providers. **Utilization Management**

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

- Identify medical necessity and appropriateness while managing benefits effectively and efficiently to ensure efficiency of the health care services across the continuum of care
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs;
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization while monitoring utilization practice patterns of Providers, hospitals and ancillary Providers to identify over and under service utilization;
- Implementing comprehensive processes to monitor and control the utilization of health care resources;
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness;
- Reviewing processes to ensure care is safe and accessible;
- Ensuring that qualified health care professionals perform all components of the UM/CM processes while ensuring timely responses to Member appeals and grievances;
- Ensuring that UM decision tools are appropriately applied in determining Medical Necessity decision.

- Identify and assess the need for Case Management/Health Management through early identification of high or low service utilization and high cost, chronic or long term diseases;
- Promote health care in accordance with local, state and national standards;
- Identify events and patterns of care in which outcomes may be improved through efficiencies in UM, and to implement actions that improve performance by ensuring care is safe and accessible;
- Continually seek to improve Member and Provider satisfaction with health care and with Molina utilization processes while ensuring that UM decision tools are appropriately applied in determining medical necessity decision; and,
- Process 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 practitioner input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis
Ensuring authorized care correlates to Member's Medical Necessity need(s) & benefit plan	Retrospective Review	Monitor for possible over- or under-utilization of clinical resources
Verifying current Physician/hospital contract status	Referrals for Discharge Planning and Care Transitions	Quality oversight
Delegation oversight	Staff education on consistent application of UM functions	Monitor for adherence to CMS, NCQA©, State and health plan UM standards

Molina maintains a Utilization Management (UM) Department to work with Members and Providers in administering the Molina Utilization Management Program. You can contact the Molina UM Department toll free.

- Prior Authorization - Phone: (855) 322-4075
- Inpatient/Continued Stay - Phone: 844-557-8434 24/7 including Afterhours, Weekends, Holidays.

Molina accepts fax authorization requests:

- Inpatient Review Medicare – Fax: (866) 472-0596
- Prior Authorization Medicare – Fax: (844) 251-1451

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. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters.

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 at www.MolinaHealthcare.com or contact the UM Department telephone number above to receive a written copy. You can always find more information about Molina's UM including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer on Molina's website by accessing www.MolinaHealthcare.com or calling the UM Department at the number listed above.

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. Molina's managed care programs balance a combination of benefit design, reimbursement structure, information analysis and feedback, consumer education, and active intervention that manages cost and improves quality. Molina maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina medical management program also ensures that Molina only reimburses for services identified as a covered benefit and medically necessary. Elements of the Molina medical management program include medical necessity review, prior authorization, inpatient management and restrictions on the use of non-network Providers.

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.

Medical Necessity Review

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

Clinical Information

Molina requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to; physician

emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless required by Federal regulation or the Molina Hospital or Provider Services Agreement.

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 the current documents are posted on the Molina website.

Requests for prior authorizations to the UM Department may be made by fax or via the Provider Portal.

Providers are encouraged to use the Molina Prior Authorization Form provided on the Molina web site. If using a different form, the Provider is required to supply the following information, as applicable, for the requested service:

- Member demographic information (Name, DOB, ID #, etc.).
- Clinical information sufficient to document the Medical Necessity of the requested services
- Provider demographic information (Referring Provider and referred to Provider/facility).
- Requested service/procedure (including specific CPT/HCPCS and ICD-10 Codes).
- Location where the service will be performed.
- Member diagnosis (CMS-approved diagnostic and procedure code and descriptions).
- Pertinent medical history (include treatment, diagnostic tests, examination data).
- Requested length of stay (for inpatient requests).
- Indicate if request is for expedited or standard processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon 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. For expedited request for authorization, we make a determination 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 provide within fourteen (14) calendar 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.

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.

Molina abides by CMS rules and regulations for all pre-service requests and will allow a Peer-to-Peer conversation in limited circumstances.

- While the request for an Organization Determination (service) is being reviewed but prior to a final determination being rendered.
- While an appeal of an Organizational Determination (service) is being reviewed.
- Before a determination has been made, if the Molina Medical Director believes that a discussion with the requesting physician would assist Molina in reaching a favorable determination (within the obligatory timeframes stated above for a standard or expedited request).

Medicare says that if Molina, being a Medicare Advantage plan, decides to not provide or pay for a requested service, in whole or in part, then an Adverse Organization Determination (denial) has occurred and we must issue a written denial notice. Once the notice has been mailed or faxed to you or the Member, or Molina has phoned the Member and/or you advising that there has been an Adverse Organization Determination (denial), the appeals process then becomes available to you.

If you wish to dispute Molina's Adverse Organization Determination (denial) we may only process the request by following the Standard or Expedited appeal process. This means that if you contact Molina to request a Peer-to-Peer review, we will advise that you must follow the rules for requesting a Medicare appeal. Refer to the Complaints, Grievance and Appeals of this Provider Manual.

Requesting Prior Authorization

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

Provider Portal: Providers are encouraged to use the Molina Provider Portal for prior authorization submission. 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.

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

Service Request Form (SRF)

The SRF must be completed and an authorization obtained for all services requiring prior authorization before the service is provided, except in emergencies. Services provided emergently (as defined by Federal and State law) are excluded from the prior authorization requirements.

- A thoroughly completed SRF is essential to assure a prompt authorization.
- All shaded areas are to be completed by the referring/ordering entity.
- A copy of pertinent clinical notes, labs, imaging, etc. may be attached and substituted for the Clinical History segment of the SRF.
- To assure maximum benefit from a referral, the requesting Provider must clearly state the purpose of the service request.
- The form should be transmitted via Provider Portal, or fax to Central Program Prior Authorization Department at (844) 251-1451 for pre-service authorization review.

Health plan coverage is not authorized until the request has been reviewed and approved by Molina. Services performed without authorization may not be eligible for payment. Molina does not "retroactively" authorize services that require prior authorization.

Primary Care Practitioners (PCPs)

The PCP is always the initial source of care for Members. A Member may see the PCP without a referral and the PCP may perform essential services in the office environment.

Elective office procedures performed by the PCPs may require authorization. PCPs are able to refer a Member to a contracted specialist for consultation and treatment without a referral request to Molina. This includes consultation and treatment for Members with chronic conditions that require ongoing treatment.

Referrals to specialty care Providers outside of the network require prior authorization.

Inpatient Admission and Continued Stay

In accordance with MHC Provider service agreements, Practitioners shall submit requests for Prior Authorization of elective inpatient services to MHC's Utilization Management (UM) Department using the Service Authorization Form for elective admissions.

Emergent services do not require MHC prior authorization. However, the admitting Practitioner and/or admitting facility is required to notify the MHC UM Department, via fax number **(866) 472-0596** of an emergent admission within twenty-four (24) hours.

In accordance with the MHC Hospital Services Agreement, participating facilities shall notify MHC via the 1-800 phone numbers on Member's identification card to verify eligibility, covered services and authorization for hospital services within twenty-four (24) hours for all elective and urgent admissions

Upon receipt of notification of admission a reference number will be assigned. Upon completion of Molina review and decision the reference number will become the authorization number or denial number.

When UM staff receive request for post-admission authorization for emergent inpatient admissions, the UM staff will confirm the Member's eligibility and benefit coverage for the admission. Subsequent continued stay authorization decisions are made by the UM Care Review Clinician (CRC) or Molina Medical Directors.

In the event MHC is not notified of an emergency admission, in accordance with MHC's policies and procedures, MHC may require retrospective review and apply standardized criteria to deny non-medically necessary care.

The Molina UM staff shall request medical records be submitted to Molina UM department within twenty-four (24) hours of notification of all inpatient admissions. An extension may be made for receipt of medical records, however a decision must be made within 72 hours of notification of admission.

Initial Clinical Review Checklist:
- ER Report
- History and Physical
- Admitting Orders
- Specialty Consultations
- Supporting Clinical Documentation

If applicable, a copy of the admitting face sheet is faxed to the Member's IPA/MG and PCP by Molina UM staff to facilitate continuity of care.

All initial inpatient admission reviews will be performed, and decision documented within seventy-two (72) hours of receipt of notification. Continued stay reviews will be performed

daily for per-diem contracted rates. A minimum review will be performed every seven (7) days for DRG contracted rates.

Continued Inpatient Stay Clinical Review Checklist:
- Physician Orders
- Specialty Consultations
- Supporting Clinical Documentation

Reconsideration

Medicare does not allow a reconsideration process.

Skilled Nursing or Rehabilitation Facility Review

All admissions to SNF and Acute Rehab Facilities require authorization by the MHC UM Department. Molina will review requests according to health plan approved procedures and utilization decision-making criteria.

Appropriately licensed health professionals, e.g., Registered Nurse - RN, or Licensed Vocational Nurse – LVN, supervise all medical necessity decisions and have qualified personnel responsible for each level of utilization management (UM) decision making. Appropriate health plan personnel have authority to review and approve requests at each of these levels.

Only the physicians with current, unrestricted, California licenses may issue denials, modifications, or terminations (suspensions, or reductions of the level of treatment or services currently in process) of referral for authorizations. Molina Healthcare considers a "qualified licensed health care professional" as a licensed professional (e.g., MD or DO, dentist, psychiatrist, pharmacist (R.Ph. or PharmD for pharmaceuticals only) with appropriate clinical expertise in treating the medical or behavioral health condition and disease or MLTSS needs.

Molina Healthcare of California (MHC) subcontracted Plan Partner and Independent Practice Association (IPA) Medical Group contracts financial responsibility matrices, and UM Delegation agreements identify referral authorization responsibility for MHC and the delegated entity.

Case Investigation

Molina UM staff will determine Member eligibility
- If the Member is eligible, UM staff will determine if the requested service or item is a covered benefit. If the service or item requested is not a covered benefit, the case will be denied due to the service or item not being a covered benefit.
- If the Member is eligible and the service or item is a covered benefit, UM staff will proceed with steps necessary to complete a review for medical necessity.

UM staff will determine medical records necessary for the review of the request. Records may be requested from Providers depending on the nature of the case. When requests are received without the required documentation to make a determination, UM staff will make at least three (3) attempts to obtain additional information.

Requests are made by return fax or phone call to the requesting Provider. If necessary, Molina UM staff may call or request information from other involved Providers. The Molina UM staff may consult with the Molina Medical Director regarding what additional information to request for completing the authorization review process. The Molina Medical Director may initiate contact with the requesting Provider to request additional information and/or discuss Member's plan of care when deemed appropriate.

For urgent cases, requests for records from Providers are made no later than twenty-four (24) hours from the date and time the request was received.

Services not Requiring Prior Authorization

Some services have been designated by Molina as not requiring prior authorization. The services must be performed by appropriate types of Providers who participate with Molina and the request must be clearly defined (e.g., specified by recognized CPT or HCPCS codes with an appropriate diagnosis and diagnosis code). Care Review Processors or Care Review Clinicians will inform the Provider the service does not require a prior authorization. MHC may never require authorization for the following services:

- Emergency Room including emergency behavioral health care
- Urgent Care Services including urgent care crisis stabilization, including mental health
- Nurse midwife services
- Family Planning Services
- Preventive Care
- Basic OB/Prenatal Care
- Sexually Transmitted Disease
- HIV Testing & Counseling
  - Sensitive and confidential services (e.g., services related to sexual assault, abortion services, drug and alcohol abuse for children aged twelve [12] or over)
- Therapeutic and elective pregnancy termination
- Annual Well Woman Exam
- Optometry and diabetic retinal exam

Medical Policy

Molina UM Staff will review requests according to health plan approved procedures and utilization decision-making criteria. Molina uses written criteria or guidelines for utilization review that are based on sound medical evidence, are updated regularly, and are reviewed and approved annually or more frequently if necessary, by the MHC Health Care Services Committee (HCSC) or the Pharmacy and Therapeutics Committee. CMS and state regulations,

policies, and benefit guidance will be used as well as nationally accepted clinical criteria. If the information submitted meets the defined criteria, HCS staff may approve coverage for the services without Medical Director or consulting physician review. If an approval decision cannot be made, the request is forwarded to a Molina Medical Director or an appropriate health professional. (e.g., behavioral health clinician or pharmacist) for review and determination.

Applying Criteria

Consideration of individual patient needs or capabilities of the local health care delivery system – Practitioners are encouraged to identify special patient needs and unique capabilities or limitations of the local delivery system. By definition, such situations do not allow approval by general guidelines, so a Medical Director, consulting physician, a licensed psychiatrist or Pharmacy professional reviews these situations, giving special consideration to patient and delivery system concerns.

Same or Similar Specialty

Some requests require review by a physician, pharmacist, dentist, or behavioral health professional. These health professionals may seek specialist consultation at any time if the review requires consultation with a health care professional with the same or similar specialty appropriate for the review of the request. Consulting specialists will have board certification or training and experience appropriate to the clinical domain of the request being reviewed.

Denials

Only licensed, qualified health professionals (e.g., MD or DO, dentist, pharmacist (R.Ph. or Pharm.D. for pharmaceuticals only), are responsible for the review of cases regarding medical necessity and/or appropriateness that the UM staff cannot approve, and are responsible for and may render denial determinations. Written notification of an adverse benefit determination will include the utilization review criteria or benefits provisions used in the adverse benefit determination, identify the qualified healthcare professional who rendered the adverse benefit determination, and are signed by an authorized representative of the organization or the physician who rendered the adverse benefit determination. The written notification will also include the appeal process.

Turn Around Timeframes

Authorization requests may be “standard/non urgent” or “expedited/ urgent.” Standard reviews include non-urgent pre-service reviews, and post-service reviews. Expedited reviews include urgent pre-service reviews and urgent “emergent” inpatient reviews:

UM Decision Needed	Decision Time Frame
Standard (non-expedited) Pre-service Determinations	Within fourteen (14) business days of receiving the medical record information required to evaluate the medical necessity and appropriateness, but no longer

	than fourteen (14) calendar days of receipt of the request
Expedited Determination	Within seventy-two (72) hours of receipt of the request
*Emergent Inpatient Review	Within twenty-four (24) hours of receipt of request
Emergency Care	No Prior Authorization is Required
Post Service/Retrospective	Within thirty (30) calendar days from receipt of request

*For emergent inpatient reviews, Molina's routine practice is to place an automatic extension for the timeliness standards. This practice puts the decision time frame from "within twenty-four (24) hours of receipt of request" up to seventy-two (72) hours for the extension.

Pre-Service Reviews (Standard and Emergent)

Molina will provide notice of the review decision as expeditiously as the Member's health condition requires, but no later than the specified timeframes.

An expedited authorization review may be requested by a Member or the Member's Provider, or may be initiated by Molina. The criteria for an expedited review are when application of the time periods for making non-urgent care determinations could:

- Seriously jeopardize the Member's life or health;
- Seriously jeopardize the Member's ability to attain, maintain, or regain maximum function, or;
- Subject the Member to severe pain that cannot be managed in a way other than what has been requested (based on the opinion of a Provider who knows the patient).

Molina allows a health care practitioner with knowledge of a Member's medical condition to act as the authorized representative of the Member for all parts of the authorization request and review process.

When a Member or their Provider requests an expedited determination, Molina staff will document and evaluate the request immediately. For pre-service and concurrent reviews, a licensed health care professional will review any unclear requests. If the request does not meet criteria for an expedited review, the health care professional may discuss the request with the Member's Provider. Only a qualified licensed health care professional may deny a request for expedited review.

If Molina initiates an expedited decision and the Member or Provider objects and requests a standard review time-frame, the objection is documented and a standard review is completed as expeditiously as the Member's health condition requires, no later than fourteen (14) business days following receipt of the request for service.

The criteria used for utilization management decision making are available for Practitioners to review.

Non-Participating Providers

MHC maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Members. MHC requires Members to receive medical care within the participating, contracted network of Providers. All care provided by non-contracted, non-network Providers must be prior authorized by MHC UM. Non-network Providers may provide emergent/urgent care and dialysis 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.

Service referrals will be made to contracted, Participating (PAR) Providers within the Molina contracted Provider network whenever possible. When referrals to non- participating (non-PAR) Providers are received, Molina UM staff will contact the requesting Provider and recommend referral to a PAR Provider. Requests to non-PAR Providers will be considered on a case by case basis and must be approved by a Molina Medical Director or his/her designee. Referrals to a non-PAR Provider will be considered for, but are not limited to the following:

- Continuation of care.
- The required specialty is not available in the network.
- PAR Specialist/surgeon does not have privileges at the contracted facility.
- Higher level of care is available at a non-par facility.
- If the Member may be required to travel a distance of greater than >fifteen (15) miles (urban) or > thirty (30) miles (rural) to see a Behavioral Health Practitioner or other Specialist where care may be ongoing. (Molina Members have the right to request out-of-network care when in-network Providers are not reasonably accessible).

Authorization for coverage of requested services may be given as follows:

- Authorization not required - subject to Member eligibility, services such as emergency care do not require any utilization management review or prior authorization by Molina.
- Primary Care Physicians (PCP) are able to refer a Member to a contracted specialist for consultation and treatment without a referral request to Molina. This includes consultation and treatment for Members with chronic conditions that require ongoing treatment.
- Molina Members may seek obstetric and gynecological physician services directly from a Molina network obstetrician and/or gynecologist or directly from a Molina network family practice physician or surgeon designated by Molina as providing obstetrical and gynecological services.

Authorizations upon Notification

Some services have been designated by Molina for approval upon notification. The services must be performed by appropriate types of Providers who participate with Molina and the request must be clearly defined (e.g., specified by recognized CPT or HCPCS codes with an appropriate diagnosis and diagnosis code). Trained UM Care Review Processors may give these types of approvals.

Upon approval of the service request, the PCP's office staff will assist the Member in scheduling an appointment with the approved Provider/Practitioner. The PCP or his staff will instruct the Member to take a copy of the authorization form and/or number to the requested Provider/Practitioner.

Direct Referral

The Direct Referral process allows PCPs to provide direct access to a contracted network specialist. To ensure timely appointments and clarify medical necessity of the PCP referral; the PCP forwards a copy of the direct referral form and supporting medical records to the contracted network specialist.

For delegated Medical Groups/IPAs, please refer to your Medical Group/IPA contract for specific requirements for referrals/authorizations.

Discharge Planning Review

Discharge planning begins upon admission. Discharge Planning identifies and initiates cost effective, quality driven treatment intervention for post-hospital care needs.

Discharge planning involves a process of communication with hospitals, practitioners, vendors the Member and family (if available), to ensure that a Member's needs are met upon hospital discharge. The discharge plan must occur in a safe and timely manner.

The clinical staff is responsible for collaborating with hospital discharge planning to facilitate an appropriate discharge plan for the Member. The clinical staff reviews the medical necessity and appropriateness for select post discharge services including home health, infusion therapy, durable medical equipment, skilled nursing facility and rehabilitative services

Affirmative Statement about Incentives

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

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

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care.

- UM decision makers do not receive incentives to encourage decisions that result in underutilization.

Open Communication about Treatment

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

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

Clinical Trials

For information on clinical trials, go to www.cms.hhs.gov or call (800) MEDICARE.

Information Only: On September 19, 2000, the Health Care Financing Administration (HCFA) approved a National Coverage Policy that permits all Medicare Beneficiaries to participate in qualified clinical trials. For the initial implementation, Medicare will pay Providers and hospitals directly on a fee for service basis for covered clinical trial services for Members of Molina's Medicare plans and other Medicare HMO plans. The Provider and/or hospital conducting the clinical trial will submit all claims for clinical trial services directly to Medicare, not to the Medicare plan. This means the Member will be responsible for all Medicare fee for service deductibles and copayments for any services received as a participant in a clinical trial.

Delegated Utilization Management Functions

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

Communication and Availability to Members and Practitioners

Molina HCS staff is accessible during normal business hours, Monday through Friday (except for Holidays) from 8:30 a.m. to 5:30 p.m. for information and authorization of care. When

initiating, receiving or returning calls, the HCS staff will identify the organization, their name and title.

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. Primary Care Physicians (PCP) are notified via fax of all Nurse Advice Line encounters. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. Providers can also utilize fax and the Provider Portal for after-hours UM access, as described in this section.

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff. Callers may also contact staff directly through a private line. All staff members identify themselves by providing their first name, job title, and organization.

Levels of Administrative and Clinical Review

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

- Administrative (e.g., eligibility, appropriate vendor or participating Provider, covered service); and,
- Clinical (e.g., medically necessary).

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

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

The timelines and procedures are published in the Provider Manual and are available on www.MolinaHealthcare.com website.

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

Prospective/Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests. Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health, some durable medical equipment (DME) and Out-of-Area/Out-of-Network Professional Services. The pre-service review process assures the following:

- Member eligibility;
- Member covered benefits;

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

Inpatient Review

Molina performs inpatient review to determine medical necessity and appropriateness of an inpatient stay. The goal of inpatient review is to authorize care, identify appropriate discharge planning needs and facilitate discharge to an appropriate setting. The criteria used to determine medical necessity will be as described in "Medical Necessity Review".

The inpatient review process assures the following:
- Members are correctly assigned to observation or inpatient status;
- Services are timely and efficient;
- Comprehensive treatment plan is established;
- Member is not being discharged prematurely;
- Member is transferred to appropriate in-network hospital or alternate levels of care when clinically indicated;
- Effective discharge planning is implemented; and,
- Member appropriate for outpatient case management is identified and referred.

Molina follows payment guidelines for inpatient status determinations consistent with CMS

NOTICE Act

Under the NOTICE Act, hospitals and CAHs must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including an MA enrollee) who receives observation services as an outpatient for more than twenty-four (24) hours. See the final rule that went on display August 2, 2016 (published August 22, 2016) at:
https://www.Federalregister.gov/documents/2016/08/22/2016-18476

Inpatient Status Determinations

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

Inpatient Facility Admission

Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. Proper notification is required by Molina on the day of admission to ensure timely and accurate payment of hospital claims. Delegated Medical Groups/IPAs must have a clearly defined process that requires the hospital to notify Molina on a daily basis of all hospital admissions.

Notifications shall be submitted by fax. Contact telephone numbers and fax numbers are noted in the introduction to the Utilization Management section of this Provider Manual.

Discharge Planning

Discharge planning begins on admission, and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. Upon discharge the Provider must provide Molina with Member demographic information, date of discharge, discharge plan and disposition.

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

Post-Service Review

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

Failure to obtain authorization when required may 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, CMS Medical Coverage Guidelines, Local and National Coverage Determinations, CMS Policy Manuals, regulation and guidance and evidence based criteria sets.

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

Coordination of Care and Services

Molina staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers and Members to ensure efforts are efficient and non-duplicative. There are two (2) main coordination of care processes for Molina Members.

The first occurs when a new Member enrolls in Molina and needs to transition medical care to Molina contracted Providers. There are mechanisms within the enrollment process to identify those Members and reach out to them from the Member & Provider Contact Center 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.

Providers must offer the opportunity to provide assistance to identified Members through:
- Notification of community resources, local or state funded agencies;
- Education about alternative care; and,
- How to obtain care as appropriate.

Continuity of Care and Transition of Members

Molina provides continued healthcare services in accordance with the terms and conditions of the benefits of the Evidence of Coverage/Plan Contract for new Members who are currently under management of a non-participating Provider for an active course of treatment and who are eligible for continuation of care. Molina will also make provisions for continuity of care for existing Members who are in an active course of treatment with a Provider whose contract has

terminated with MHC or a Provider that has changed Provider groups and who are eligible for continuation of care.

Scope of Conditions:

- Member can demonstrate an existing relationship with the out-of- network Provider, prior to enrollment;
- The Provider is willing to accept payment from the Molina based on the current Medicare fee or Medi-Cal fee schedule, as applicable; and
- Molina would not exclude the Provider from the Provider network due to documented quality of care concerns.

If a Member changes MMPs, the COC period may start over one time. If the Member changes MMP's a second time (or more) the COC period does not start over, meaning that the Member does not have the right to a new twelve (12) month period depending on the type of Provider. If a Member changes MMPs, this COC policy does not extend to out-of-network Providers that the Member accessed through their previous MMP.

Continuity of care policies apply regardless of whether a Member voluntarily joins or passively enrolls in an MMP. If a Member opts out or disenrolls from Cal MediConnect and later re-enrolls in Cal MediConnect, the Member has the right to a twelve (12) month continuity of care period, regardless of whether the Member received continuity of care in the past.

When a Member, their authorized representative on file with Medi-Cal or their Provider makes a request to Molina for COC, Molina must begin to process the request within five (5) working days after receipt of the request. The COC process begins when Molina determines there is a pre-existing relationship and has entered into an agreement with the Provider.

Molina shall accept requests for COC over the telephone, according to the requestor's preference, and shall not require that the requestor complete and submit a paper or computer form. To complete a telephone request, Molina may take any necessary information from the requestor over the telephone.

Molina shall accept and approve retroactive requests for COC, and claim payments that meet all COC requirements, with the exception of the requirement to abide by Molina's utilization management policies. The services that are subject of the request must have occurred after the Member's enrollment with Molina and Molina must have the ability to demonstrate that there was an existing relationship between the Member and Provider prior to the Member's enrollment with Molina. Molina shall only approve retroactive requests that meet the following requirements:

- Have dates of services that occur after September 29, 2014.
- Have dates of services within thirty (30) calendar days of the first date of service for which the Provider is requesting, or has previously requested, COC retroactive reimbursement.
- Are submitted within thirty (30) calendar days of the first service for which retroactive COC is being requested or denial from another entity when the claim was incorrectly submitted. Molina shall accept retroactive requests that are submitted more than thirty (30) days after

the first service if the Provider can document that the reason for the delay is that the Provider unintentionally sent the request to the incorrect entity and the request is sent within thirty (30) days of the denial from the other entity.

Molina will determine if a relationship exists through use of data provided to the MMP by CMS and DHCS, such as FFS utilization data from Medicare or Medi-Cal. A member or his/her Provider may also provide information to the MMP that demonstrates a pre-existing relationship with a Provider. A beneficiary may not attest to a pre-existing relationship (instead actual documentation must be provided) unless the MMP makes this option available to him/her.

Following identification of pre-existing, the MMP must contact the Provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement or other form of relationship to establish a continuity of care relationship for the beneficiary.

Each COC request must be completed within thirty (30) days from the date Molina received the request, within fifteen (15) calendar days if the Member's medical condition requires more immediate attention such as appointments or pressing care needs, or within three (3) calendar days if there is risk of harm to the Member.

A COC request is considered completed when the Member is informed of his/her right of continued access or Molina and the out-of-network FFS or prior plan Provider are unable to agree to a rate; Molina has documented quality of care issues; or Molina makes a good faith effort to contact the Provider and the Provider is non-responsive for thirty (30) calendar days.

An approved out-of-network Provider cannot refer the Member to another out-of-network Provider without authorization from Molina. Molina will make the referral, if medically necessary and if Molina does not have an appropriate Provider within its network.

For DME, transportation and other ancillary services, Molina will provide COC for services to ensure that each Member continues to have access to medically necessary items and services, as well as medical and LTSS Providers, but is not obligated to use out-of-network Providers who are determined to have pre-existing relationships for the applicable twelve (12) months.

Molina must allow Members to continue to use of any drugs that are part of a prescribed therapy in effect for the Member immediately prior to the date of enrollment, whether or not the drug is covered by Molina, until the prescribed therapy is no longer prescribed by the contracting.

Molina, at the request of the Member, provides for the completion of covered services by a terminated or nonparticipating health plan Provider.

Molina is required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age thirty-six (36) months and surgeries or other procedures that were previously authorized as part of a documented course of treatment.

Molina will not require a Member who is a long term resident of a nursing facility (NF) prior to enrollment to change NFs during the duration of the Duals Demonstration Project, provided that the facility is licensed by the California Department of Public Health (CDPH), meets acceptable quality standards, and the facility and Molina agree to Medicare rates if the services is a Medicare service, or Medi-Cal rates if the service is a Medi-Cal service, in accordance with the three (3)-way contract.

If a Member residing in a Skilled Nursing Facility (SNF) leaves the SNF, the Member has the right to return to the same SNF where they previously resided under the COC policy.

If a Provider meets all of the necessary requirements, including entering into a contract, letter of agreement, single-case agreement or other form of relationship with Molina, Molina must allow the Member to have access to that Provider for the length of the COC period unless the Provider is only willing to work with Molina for a shorter timeframe. In this case, Molina must allow the Member to have access to that Provider for the shorter period of time.

At any time, Members may change their Provider regardless of whether or not a COC relationship has been established. When the COC agreement has been established, Molina must work with the Provider to establish a care plan for the Member.

Upon completion of a COC request, Molina must notify the Member of the following within seven (7) calendar days:

- The request approval or denial, and if denied, the Member's appeal and grievance rights;
- The duration of the COC arrangement;
- The process that will occur to transition the Member's care at the end of the COC
- period; and,
- The Member's right to choose a different Provider from Molina's Provider network.

Molina notifies the Member thirty (30) calendar days before the end of the COC period about the process that will occur to transition the Member's care at the end of the COC period.

This process shall include engaging with the Member and Provider before the end of the COC period to ensure continuity of services through the transition to a new Provider.

Consistent with the provisions of the contract, Molina is not required to provide Provider COC with an out-of-network Provider if any of the following circumstances exist:

- Molina is not required to provide COC for services not covered by Medi-Cal or Medicare.
- The following Providers are not eligible for COC: Providers of DME, transportation, other ancillary services or carved out services.
- The Provider does not agree to abide by Molina's utilization management policies or a reimbursement rate.

Molina will provide COC to Members through continued access to a CBAS (Community Based Adult Services) Provider with whom there is an existing relationship for up to twelve (12)

months after Member enrollment or a Long Term Care (LTC) Provider with whom there is an existing relationship through December 31, 2016. The requirement shall include out-of-network Providers if there are no quality of care issues and the Provider will accept contractor or Medi-Cal FFS rates, whichever is higher.

Requirements for Delegated Entities – When a Member transitions into the Molina MMP line of business, and has an existing relationship with a PCP that is in the Molina Provider network, Molina must assign the Member to the PCP, unless the Member chooses another PCP. Since Molina contracts with delegated groups, Molina must assign the Member to a delegated entity that has the Member's preferred PCP in its network.

Additionally, when a Member transitions into the MMP, and has an existing relationship with a PCP and/or specialist within Molina's Provider network, the Member must be allowed to continue treatment for the continuity of care period with these Providers, even if the Providers belong to different delegated entities.

Balance billing is prohibited by State and Federal law. A Provider may not bill a beneficiary for any charges that are not reimbursed by Medicare or Medi-Cal, if the service is covered by Medicare or Medi-Cal. The only exception is that Providers may bill Medi-Cal beneficiaries who have a monthly share of cost obligation, but only until that obligation is met for the applicable month.

Organization Determinations

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

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to deny requests (adverse determination);
- Discontinuation of a service;
- Payment for temporarily, out-of-the-area renal dialysis services;
- Payment for emergency services, post-stabilization care or urgently needed services; and,
- Payment for any other health service furnished by a Provider that the Member believes is covered under Medicare or if not covered under Medicare, should have been furnished, arranged for or reimbursed by Molina or the delegated Medical Group/IPA or other delegated entity.

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

Clinical criteria do not replace Medicare Coverage Determinations when making decisions regarding appropriate medical treatment for Molina Members. As a Medicare Plan, Molina and its delegated Medical Groups/IPAs, or other delegated entity at a minimum, cover all services and items required by Medicare.

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

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

1. **Standard Initial Organization Determinations (Pre-service) –** Standard initial organization determinations must be made as soon as medically indicated, within a maximum of fourteen (14) calendar days after receipt of the request. The table under number four (4) below describes the CMS required decision timeframes and notification requirements followed by Molina.

2. **Expedited Initial Organization Determinations –** A request for expedited determinations may be made. An organization determination is expedited if applying the standard determination timeframes could seriously jeopardize the life or health of the Member or the Member's ability to re-gain maximum function. Molina and any delegated Medical Group/IPA or other delegated entity is responsible to appropriately log and respond to requests for expedited initial organization determinations.
   - Expedited Initial Determinations must be made as soon as medically necessary, within seventy-two (72) hours (including weekends and holidays) following receipt of the validated request; and,
   - Delegated Medical Groups/IPAs or other delegated entities are responsible for submitting a monthly log of all Expedited Initial Determinations to Molina's Delegation Oversight Department that lists pertinent information about the expedited determination including Member demographics, data and time of receipt and resolution of the issue, nature of the problem and other information deemed necessary by Molina or the Medical Group/IPA or other delegated entities. The table under number four (4) below describes the CMS required decision timeframes and notification requirements followed by Molina.

3. **Written Notification of Denial –** The Member must be provided with written notice of the determination, if the decision is to deny, in whole or in part, the requested service or payment. If the Member has an authorized representative, the representative must be sent a copy of the denial notice. The appropriate written notice, that has CMS approval, must be issued within established regulatory and certification timelines. The adverse

organization determination templates shall be written in a manner that is understandable to the Member and shall provide the following:

- The specific reason for the denial, including the precise criteria used to make the decision that takes into account the Member's presenting medical condition, disabilities and language requirements, if any;
- Information regarding the Member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the Member's behalf;
- Include a description of both the standard and expedited reconsideration process, timeframes and conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;
- Payment denials shall include a description of the standard reconsideration process, timeframes and other elements of the appeal process; and,
- A statement disclosing the Member's right to submit additional evidence in writing or in person.
- Failure to provide the Member with timely notice of an organization determination constitutes an adverse organization determination which may be appealed.

4. Termination of Provider Services (SNF, HH, CORF)/Issuance of Notice of Medicare Non- Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC) – When a termination of authorized coverage of a Member's admission to a skilled nursing facility (SNF) or coverage of home health agencies (HHA) or comprehensive outpatient rehabilitation facility (CORF) services occurs, the Member must receive a written notice two (2) calendar days or two (2) visits prior to the proposed termination of services.

Molina or the delegated Medical Group/IPA must coordinate with the SNF, HHA or CORF Provider to ensure timely delivery of the written notice, using the approved NOMNC. Delivery of the notice is not valid unless all elements are present and Member or authorized representative signs and dates the notice to document receipt.

- The NOMNC must include the Member's name, delivery date, date that coverage of services ends and QIO information;
- The NOMNC may be delivered earlier than two (2) days before coverage ends;
- If coverage is expected to be fewer than two (2) days in duration, the NOMNC must be provided at the time of admission; and,
- If home health services are provided for a period of time exceeding two (2) days, the NOMNC must be provided on or before the second to last service date.

Molina (or the delegated entity) remains liable for continued services until two (2) days after the Member receives valid notice. If the Member does not agree that covered services should end, the Member may request a Fast Track Appeal by the Quality Improvement Organization (QIO) by noon of the day following receipt of the NOMNC, or by noon of the day before coverage ends.

Upon notification of the Member's request for the Fast Track Appeal, Molina (or the delegated entity) must provide a detailed notice to the Member and to the QIO no later than the close of business, using the approved DENC explaining why services are no longer necessary or covered. The DENC must include the following:

- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;
- A description of any applicable coverage rule, instruction or other policy, citations, or information about how the Member may obtain a copy of the policy from Molina or the delegated entity;
- Any applicable policy, contract provision or rationale upon which the termination decision was based; and,
- Facts specific to the Member and relevant to the coverage determination that is sufficient to advise the Member of the applicability of the coverage rule or policy to the Member's case.

Reporting of Suspected Abuse of an Adult

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

Los Angeles County
(800) 540-4000 – Within CA
(213) 639-4500 – Outside CA
(800) 272-6699 – TDD
Online Reporting:
https://reportChildAbuseLA.org

San Diego County
(858) 560-2191

(800) 344-6000

Imperial County
(760) 337-7750

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

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

Adult Abuse:

Los Angeles County
Community & Senior Services
3333 Wilshire Blvd. Suite 400
Los Angeles, CA 90010
24-Hour Abuse Hotline: (877) 477-3646
APS Mandated Reporter Hotline: M-F, 8:30-5:00 (888) 202-4248

Sacramento County
Department of Health & Human Services
P.O. Box 269131
Sacramento, CA 95826
24 Hour Abuse Hotline: (916) 874-9377; (916) 854-9341 fax

San Diego County
Aging & Independence Services
P.O. Box 23217
San Diego, CA 92193-3217
24 Hour Abuse Hotline: (800) 339-4661 or (800) 510-2020
(858) 495-5247 fax

Imperial County
Department of Social Services
2999 South 4th Street
El Centro, CA 92243
24 Hour Abuse Hotline: (760) 337-7878; (760) 336-8593 fax

Riverside County
Department of Public Social Services - Adult Services Division
4060 County Circle Drive
Riverside, CA 92501

24 Hour Abuse Hotline: (800) 491-7123; (951) 358-3969 fax

San Bernardino County
Department of Aging and Adult Services
686 East Mill Street
San Bernardino, CA 92415
24 Hour Abuse Hotline:
(877) 565-2020; (909) 388-6718 fax

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 Utilization Management Committee and the proper State agency.

Emergency and Post-Stabilization Services

Emergency Services means: Care given for a medical emergency when a Member believes that his/her health is in serious danger when every second counts.

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 Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: Molina contracts with vendors that provide twenty-four (24) hour Emergency Services for ambulance and hospitals.

Molina and its contracted Providers must provide emergency services and post-emergency stabilization and maintenance services to treat any Member with an Emergency Medical Condition in compliance with Federal Law. An Emergency Medical Condition is defined as a medical condition manifesting itself 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 Member including the health of a pregnant woman and/or her unborn child in serious jeopardy;

- Serious impairment to bodily functions;
- Serious dysfunction of any body part; and/or,
- Serious disfigurement.

Molina covers maintenance care and post-stabilization services which are medically necessary, non-emergency services. Molina or its delegated entity arranges for post-stabilization services to ensure that the patient remains stabilized from the time the treating hospital requests authorization until the time the patient is discharged or a contracting medical provider agrees to other arrangements.

Pre-approval of emergency services is not required. Molina requires the hospital emergency room to contact the Member's primary care Provider upon the Member's arrival at the emergency room. After stabilization of the Member, Molina requires pre-approval of further post-stabilization services by a participating Provider or other Molina representative. Failure to review and render a decision on the post-stabilization pre-approval request within one (1) hour of receipt of the call shall be deemed an authorization of the request.

Molina or its delegated entity is financially responsible for these services until Molina or its delegated entity becomes involved with managing or directing the Member's care.

Molina and its delegated entity provides urgently needed services for Members temporarily outside of the service area but within the United States or who have moved to another service area but are still enrolled with. Urgent Services are covered services that are medically necessary and are needed urgently, typically the same day or within two (2) days of onset of symptoms, as judged by a prudent layperson.

Emergency Department Support Unit

While the Member is in the Emergency Room, please **fax all clinical records to the dedicated EDSU fax number: (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, and 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.

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 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.

Please fax clinical documentation to: **(866) 472-0596**

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**

Primary Care Providers

Molina provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina. Molina's Medicare Members are required to see a PCP who is part of the Molina Network. Molina's Medicare Members may select or change their PCP by contacting Molina.

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Referrals from a Molina PCP are required for a Member to receive specialty services, however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral services.

Molina will help to arrange specialty care outside the network when Providers are unavailable or the network is inadequate to meet a Member's medical needs. To obtain such assistance contact the Molina UM Department. Referrals to specialty care outside the network require prior authorization from Molina.

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.

Case Management

The Case Management Program provides care coordination and health education for disease management, as well as identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals. Case Management focuses on the delivery of quality, cost-effective, and appropriate health care services for Members with complex and chronic care needs. Members may receive health risk assessments that help identify medical, mental health and medication management problems to target highest-needs members who would benefit from assistance and education from a case manager. Additionally, functional, social support and health literacy deficits are assessed, as well as safety concerns and caregiver needs. To initiate the case management process, the Member is screened for appropriateness for case management program enrollment using specified criteria. Criteria are used for opening and closing cases appropriately with notification to Member and Provider.

1. The role of the Case Manager includes:

- Coordination of quality and cost-effective services;
- Promotion of early, intensive interventions in the least restrictive setting;
- Assistance with transitions between care settings;
- Provision of accurate and up-to-date information to Providers regarding completed health assessments and care plans;
- Creation of individualized care plans, updated as the Member's health care needs change;
- Facilitation of Interdisciplinary Care Team meetings;
- Utilization of multidisciplinary clinical, behavioral and rehabilitative services;

- Referral to and coordination of appropriate resources and support service, including Long Term Services & Supports;
- Attention to Member satisfaction;
- Provision of ongoing analysis and evaluation;
- Protection of Member rights; and,
- Promotion of Member responsibility and self-management.

2. Referral to Case Management may be made by any of the following entities:
- Member or Member's designated representative;
- Member's primary care Provider;
- Specialists;
- Hospital Staff;
- Home Health Staff; and,
- Molina staff.

Molina Special Needs Plan Model of Care

Note: Model of Care Enhancements do not apply to standard MAPD programs.

1. **Targeted Population –** Molina operates Medicare Dual Eligible Special Needs Plans (SNP) for Members who are fully eligible for both Medicare and Medicaid. In accordance with CMS regulations, Molina has a SNP Model of Care that outlines Molina's efforts to meet the needs of the dual eligible SNP Members. This population has a higher burden of multiple chronic illnesses and sub-populations of frail/disabled Members than other Medicare Managed Care Plan types. The Molina Dual Eligible Special Needs Plan Model of Care addresses the needs of all sub-populations found in the Molina Medicare SNP.

2. **Care Management Goals** – Utilization of the Molina SNP extensive network of primary Providers, specialty Providers and facilities, in addition to services from the Molina Medicare SNP Interdisciplinary Care Team (ICT), will improve access of Molina Members to essential services such as medical, mental health and social services. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:

a. Molina Geo Access reports showing availability of services by geographic area;

b. Number of Molina SNP Members utilizing the following services:
   - Primary care Provider (PCP) Services
   - Specialty (including Mental/Behavioral Health) Services
   - Inpatient Hospital Services
   - Skilled Nursing Facility Services
   - Home Health Services
   - Mental/Behavioral Health Facility Services

- Durable Medical Equipment Services
- Emergency Department Services
- Supplemental Transportation Benefits
- Long Term Services and Supports

c. HEDIS® use of services reports;
d. Member Access Complaint Report;
e. Medicare CAHPS® Survey; and
f. Molina Provider Access Survey.

3. Members of the Molina SNP will have access to quality affordable healthcare. Since Members of the Molina SNP are full dual eligible for Medicare and Medicaid they are not subject to out of pocket costs or cost sharing for covered services. Molina focuses on delivering high quality care. Molina has an extensive process for credentialing network Providers, ongoing monitoring of network Providers and peer review for quality of care complaints. Molina maintains recommended clinical practice guidelines that are evidence based and nationally recognized. Molina regularly measures Provider adherence to key provisions of its clinical practice guidelines. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:

a. HEDIS® report of percent Providers maintaining board certification;
b. Serious reportable adverse events report;
c. Annual report on quality of care complaints and peer reviews;
d. Annual PCP medical record review;
e. Clinical Practice Guideline Measurement Report;
f. Licensure sanction report review; and,
g. Medicare/Medicaid sanctions report review.

4. By having access to Molina's network of primary care and specialty Providers as well as Molina's programs that include Care Management Service Coordination, Nurse Advice Line, Utilization Management and Quality Improvement, SNP Members have an opportunity to realize improved health outcomes.

Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:

a. Medicare HOS; and,
b. Chronic Care Improvement Program Reports.

5. Molina Members will have an assigned point of contact for their coordination of care. According to Member's need, this coordination of care contact point might be their Molina Network PCP or Molina Case Manager. Care will be coordinated through a single point of contact who interact with the ICT to coordinate services as needed.

6. **Members of the Molina Medicare SNP will have improved transitions of care across healthcare settings, Providers and health services.** The Molina Medicare SNP has programs designed to improve transitions of care. Authorization processes enable Molina staff to become aware of transitions of care due to changes in healthcare status as they occur. Molina case managers work with Members, their caregivers and their Providers to assist in care transitions. In addition Molina has a program to provide follow-up telephone calls or face to face visits to Members while the Member is in the hospital and after hospital discharge to make sure that they received and are following an adequate discharge plan. The purpose is to establish a safe discharge plan and to evaluate if the Members are following the prescribed discharge plan once they are home, have scheduled a follow up physician appointment, have filled all prescriptions, understand how to administer their medications and have received the necessary discharge services such as home care or physical therapy. All Members experiencing transition receive a post discharge educational letter advising them of benefits and services offered by Molina. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:
   a. Transition of Care Data;
   b. Re-admission within thirty (30) Days Report;
   c. Provider adherence to notification requirements; and,
   d. Provider adherence to provision of the discharge plan.

7. **Members of the Molina Medicare SNP will have improved access to preventive health services.** The Molina Medicare SNP expands the Medicare preventive health benefit by providing annual preventive care visits at no cost to all Members. This allows PCPs to coordinate preventive care on a regular basis. Molina uses and publicizes nationally recognized preventive health schedules to its Providers. Molina also makes outreach calls to Members to remind them of overdue preventive services and to offer assistance with arranging appointments and providing transportation to preventive care appointments.

   Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks: HEDIS® Preventive Services Reports.

8. **Members of the Molina Medicare SNP will have appropriate utilization of healthcare services.** Molina utilizes its Utilization Management team to review appropriateness of requests for healthcare services using appropriate Medicare criteria and to assist in Members receiving appropriate healthcare services in a timely fashion from the proper Provider.

   Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks: Molina Over and Under Utilization Reports.

9. **Staff Structure and Roles** - The Molina Medicare SNP has developed its staff structure and roles to meet the needs of dual eligible Special Needs Plan Members. Molina's background as a Provider of Medicaid Managed Care services in the states that it serves allows the plan to have expertise in both the Medicare and Medicaid benefits that Members have access to in the Molina Medicare Dual Eligible SNP. Molina has many years of experience managing this population of patients within Medicaid to go with its experience of managing the Medicare part of their benefit. Molina's Member advocacy and service philosophy is designed and administered to assure Members receive value-added coordination of health care and services that ensures continuity and efficiency and that produces optimal outcomes. Molina employed staff are organized in a manner to meet this objective and include:

a. **Care Management Team** that forms a main component of the interdisciplinary care team (ICT) comprised of the following positions and roles:

   i. Care Review Processors – Gather clinical information about transitions in care and authorizations for services, authorize services within their scope of training and job parameters based upon predetermined criteria, serve as a resource for nursing staff in collecting existing clinical information to assist nursing assessments and care team coordination.

   ii. Care Review Clinicians (LVN/RN) – Assess, authorize, coordinate and evaluate services, including those provided by specialists and therapists, in conjunction with the Member, Providers and other team members based on Member's needs, medical necessity and predetermined criteria.

   iii. Case Managers (CM) (nurse, social workers, Behavioral Health professionals) – Work with the IRC and Transition Coaches to support members after the thirty (30) day transition period by assessing, authorizing, coordinating, triaging and evaluating services in conjunction with the Member, Providers and other team members based on Member's needs and preferences. The CM supports Members, caregivers and Providers in Member transitions between care settings including facilitation of information retrieval from ancillary Providers, consultants, and diagnostic studies for development, implementation and /or revision of the integrated care plan. The CM continues to work with the Member to identify and address issues regarding Member's medical, behavioral health, LTSS and social needs and maintains and updates the integrated care plan and assists in the coordination of needed services. Updates to the ICP are communicated by the CM to the Member and participants of the ICT based on member preference.

   iv. Health Manager – Develop materials for Health Management programs. Serve as resource for Members and Molina staff members regarding Health Management Program information, educates Members on how to manage their condition.

   v. Transitions of Care Coach – (Medical and Behavioral Health Clinicians) – The Transitions Coach is notified by and works closely with the IRC and functions as a facilitator of interdisciplinary collaboration across the transition, engaging the Member and family caregivers, facility and

Providers to participate in the formation and implementation of an individualized plan of care including interventions to mitigate the risk of re-hospitalization. The primary role of the Transitions staff is to follow the Member closely for thirty (30) days post discharge to ensure a safe transition to the least restrictive most inclusive setting of the Member's choice and to encourage self-management and direct communication between the Member and Provider.

vi. Community Connectors/Health Workers – the Community Connectors are community health workers trained by Molina to serve as Member navigators and promote health within their own communities by providing education, advocacy and social support. Community Connectors also help Members navigate the community resources and decrease identified barriers to care.

vii. Behavioral Health Team includes Molina employed clinical behavioral health specialists to assist in behavioral health care issues. A board certified Psychiatrist functions as a Behavioral Health Medical Director and as a resource for the Integrated Care Management and Utilization Management Teams and Providers regarding Member's behavioral health care needs and care plans.

b. **Member & Provider Contact Center** – Serves as a Member's initial point of contact with Molina and main source of information about utilizing the Molina Medicare SNP benefits and is comprised of the following positions:

i. Member Services Representative – Initial point of contact to answer Member questions, assist with benefit information and interpretation, provide information on rights and responsibilities, assist with PCP selection, advocate on Members' behalf, assist Members with interpretive/translation services, inform and educate Members on available services and benefits, act as liaison in directing calls to other departments when necessary to assist Members.

ii. Member Services Managers/Directors – Provide oversight for member services programs, provide and interpret reporting on member services functions, evaluate member services department functions, identify and address opportunities for improvement.

c. **Appeals and Grievances Team** that assists Members with information about and processing of appeals and grievances:

i. Appeals and Grievances Coordinator – Provide Member with information about appeal and grievance processes, assist Members in processing appeals and grievances, notifies Members of appeals and grievance outcomes in compliance with CMS regulations.

ii. Appeals and Grievances Manager – Provide oversight of appeals and grievance processes assuring that CMS regulations are followed, provide and interpret reporting on A&G functions, evaluate A&G department functions, identify and address opportunities for improvement.

d. **Quality Improvement Team** that develops, monitors, evaluates and improves the Molina Medicare SNP Quality Improvement Program. QI Team is comprised of the following positions:
   i. QI Specialist – Coordinate implementation of QI Program, gather information for QI Program reporting and evaluations, provide analysis of QI Program components.
   ii. QI Managers/Directors – Development and oversight of QI Program which includes program reporting and evaluation to identify and address opportunities for improvement.
   iii. HEDIS® Specialist – Gather and validate data for HEDIS® reporting.
   iv. HEDIS® Manager – Oversight and coordination of data gathering and validation for HEDIS® reporting, provide and interpret HEDIS® reports, provide preventive services missing services report.

e. **Medical Director Team** has employed board-certified physicians. Medical Directors and Healthcare Services Program Manager - Responsible for oversight of the development, training and integrity of Molina's Medicare SNP Healthcare Services and Quality Improvement programs. Resource for Integrated Care Management and Care Access and Monitoring Teams and Providers regarding Member's health care needs and care plans. Selects and monitors usage of nationally recognized medical necessity criteria, preventive health guidelines and clinical practice guidelines.

f. **Behavioral Health Team** has Molina employed health specialists to assist in behavioral health care issues:
   i. Psychiatrist Medical Director – Responsible for oversight of the development and integrity of behavioral health aspects of Molina's Medicare SNP Healthcare Services and Quality Improvement programs. Resource for Integrated Care Management and Utilization Management Teams and Providers regarding Member's behavioral health care needs and care plans. Develops and monitors usage of behavioral health related medical necessity criteria and clinical practice guidelines.

g. **Pharmacy Team** has employed pharmacy professionals that administer the Part D benefit and assist in administration of Part B pharmacy benefits.
   i. Pharmacy Technician – Serves as point of contact for Members with questions about medications, pharmacy processes, and pharmacy appeals and grievances.
   ii. Pharmacist – Provide authorizations for Part D medications. Provide oversight of pharmacy technician performance, resource for Care Management Teams, other Molina staff and Providers, provide review of post discharge medication changes, review Member medication lists and report data to assure adherence and safety, interact with Members and Providers to discuss medication lists and adherence.

h. Healthcare Analytics Team

i. Healthcare Analysts – Assist in gathering information, developing reports, providing analysis for health plan to meet CMS reporting requirements, evaluate the model of care and review operations.

ii. Director Healthcare Analytics – Develop predictive modeling programs used to assist in identifying Members at risk for future utilization, oversight of health care reporting and analysis program, oversight of clinical aspects of Part C Quality Reporting, oversight of health care analysts.

i. **Health Management Team** is a Molina care team that provides multiple services to Molina's Medicare SNP Members. This team provides population based Health Management Programs for low risk Members identified with asthma and depression. The Health Management team also provides a twenty-four/seven (24/7) Nurse Advice Line for Members, outbound post hospital discharge calls and outbound preventive services reminder calls. The Health Management team is comprised of the following positions:

i. Medicare Member Outreach Assistant – Make outbound calls related to gathering and giving information regarding Health Management programs, make outbound calls to review whether Member received hospital discharge plan, make referrals to Care/Case Managers when Members have questions about their hospital discharge plan, make outbound preventive service reminder calls.

ii. Nurse Advice Line Nurse – Receive inbound calls from Members and Providers with questions about medical care and after-hours issues that need to be addressed, give protocol based medical advice to Members, direct after-hours transitions in care.

j. Interdisciplinary Care Team

i. Composition of the Interdisciplinary Care Team

ICT members are determined by Member preferences and inclusion decisions are made collaboratively and with respect to the Member's right to self-direct care. Family Members and caregiver participation is encouraged and promoted, with the Member's permission. Members are educated during the assessment process on how to access the ICT and the Case Manager provides invitations either verbally or in writing to scheduled ICT meetings. The Member can opt out of the care team and/or choose to limit the role of their caregivers, or any other Provider or members of the care team.

The ICT is typically composed of:

- Member

- Care Giver
- PCP, Nurse Practitioner (NP), Physician Assistant (PA)
- Primary specialty physician
- Case Manager
- Molina Medical Director
- Molina Social worker
- Molina Behavioral health staff
- Molina Pharmacist

Additional members of the ICT may be added on a case-by-case basis depending on a Member's conditions/health status, health risk assessment results and ICP and Member preference:

- Molina Transitions staff
- Hospitalist
- Molina Community Connectors
- Network Medical Specialty Providers
- Network Home Health Providers
- Network or County Behavioral Health Providers
- Case Managers from County Agencies
- LTSS facility or HCBS staff
- Acute Care Hospital Staff
- Skilled Nursing Facility Staff
- Long Term Acute Care Facility Staff
- Certified Outpatient Rehabilitation Staff
- Behavioral Health Facility Staff
- Renal Dialysis Center Staff
- Out of Network Providers or Facility Staff (until a member's condition of the state of the Molina Network allows safe transfer to network care)

ii. Adding Members to the ICT will be considered when:

- The Member makes such a request.
- Member is undergoing a transition in healthcare setting.
- Member sees multiple medical specialists for care on a regular and ongoing basis.
- Member has significant complex or unresolved medical diagnoses identified in the member's health risk assessments.
- Member has significant complex or unresolved mental health or chemical dependency diagnoses.
- Member has significant complex or unresolved pharmacy needs.
- Is indicated by health risk assessment or ICP.

iii. Molina's Medicare SNP Members and their caregivers participate in the Molina ICT through many mechanisms including:

- Formal, scheduled, meetings with Molina case managers, physicians, pharmacists, social workers and Behavioral Health staff including the PCP and other external Providers of the Member's choosing.
- Participation in external vendor case review such as home health or nursing home case rounds.
- Molina staff accompanying the Member to their physician or treatment appointments.
- Three (3) way discussions with the Member, Molina staff, and any external Provider of home services.
- Discussions about their health care with their PCP.
- Discussions about their health care with medical specialists or ancillary Providers who are participating in the Member's care as directed by the Member's PCP.
- Discussions about their health care with facility staff who are participating in the Member's care as directed by the Member's PCP.
- During the assessment process by Molina Staff.
- Discussions about their health care with their assigned Molina Integrated Care Management Team members.
- Discussions with Molina Staff in the course of Health Management programs, preventive health care outreach, Care Transitions program and other post hospital discharge outreach.
- Discussion with Molina Pharmacists about complex medication issues.
- Through the appeals and grievance processes.
- By invitation during case conferences or regular ICT meetings.
- By request of the Member or caregiver to participate in regular ICT meetings.

iv. ICT Operations and Communication

The Molina Medicare SNP Member's assigned PCP and the Molina Integrated Care Management Team will provide the majority of the Integrated Care Management in the ICT. The Member's assigned PCP will be a primary source of assessment information, care plan development and Member interaction within the ICT. The PCP will regularly (frequency depends on the Member's medical conditions and status) assess the Member's medical conditions, develop appropriate care plans, request consultations, evaluations and care from other Providers both within and, when necessary, outside the Molina Network. The Molina Integrated Care Management Team will also provide assessments, care plan development and individualized care goals.

v. The Integrated Care Management Team will be primarily involved during assessment periods, individualized care plan follow-up, transitions of care settings, routine case management follow-up, and significant changes in the Member's health status. In addition, the Care management team will be involved after referral from other Molina Staff (i.e., Utilization Management staff, Pharmacists), requests for assistance from PCPs, requests for assistance from Members/caregivers. Transitions in care and significant changes in health status that need follow-up will be detected when services requiring prior authorization are requested by the Member's PCP or other Providers (signaling a transition in care or complex medical need). The PCP and Integrated Care Management Team will decide when additional ICT meetings are necessary and will schedule them on "as needed" basis.

vi. The ICT will hold regular case conferences for Members with complex health care needs and/or complex transition issues. Members will be chosen for case conferences based on need as identified by the Molina Integrated Care Management Team, when referred by their Provider or at the request of the Member/caregiver. All members of the ICT will be invited to participate in the case conference. Members and/or their caregivers will be invited to participate when feasible. The Molina CM will provide a case conference summary for each Member case discussed. The summary is then reviewed with the Member to ensure that he/she is comfortable with the plan of care. The Care Plan is updated with the Member agreement based on the case conference recommendations to align with Providers' treatment plans. Case conference summaries will be provided to all applicable ICT members as determined by the Member or their representative upon request.

vii. Communication between ICT members will be compliant with all applicable HIPAA regulations and will occur in multiple ways including:
- The Molina CM may facilitate sharing of Member's health and LTSS records from ICT Providers before, during, and after transitions in care and during significant changes in the health status of Members, for those health services that require prior authorization, or during the course of regular case management activities
- Through consultations among those involved in the Member's care, which include as warranted county BH Case Managers, social workers, psychiatrists, home health workers, PCPs, Molina medical directors, pharmacists, dieticians, medical specialists, LTSS Providers and agencies, family members, and other caregivers
- Case conference summaries available to all Members and active members of the ICT based on Member preference.
- Updated ICPs are reviewed and shared with members of the ICT as often as determined by regulatory requirements, with significant

changes in health status, or at minimum annually by clinical Molina staff in conjunction with annual Health Risk Assessments.
- Additional opportunities for review and revision of care plans may exist when ICT members become aware of member transitions in health care settings or significant changes in Member health care status.

10. Provider Network - The Molina Medicare SNP maintains a network of Providers and facilities that has a special expertise in the care of Dual Eligible Special Needs Plans Members. The population served in Dual Eligible Special Needs Plans has a disproportionate share of physical and mental/behavioral health disabilities. Molina's network is designed to provide access to medical care for the Molina Medicare SNP population.

The Molina Medicare SNP Network has facilities with special expertise to care for its SNP Members including:

- Acute Care Hospitals
- Long Term Acute Care Facilities
- Skilled Nursing Facilities
- Rehabilitation Facilities (Outpatient and Inpatient)
- Mental/Behavioral Health/Substance Abuse Inpatient Facilities
- Mental/Behavioral Health/Substance Abuse Outpatient Facilities
- Outpatient Surgery Centers (Hospital-based and Freestanding)
- Laboratory Facilities (Hospital-based and Freestanding)
- Radiology Imaging Centers (Hospital-based and Freestanding)
- Renal Dialysis Centers
- Emergency Departments (Hospital-based)
- Urgent Care Centers (Hospital-based and Freestanding)
- Diabetes Education Centers (Hospital-based)

The Molina Medicare SNP has a large community based network of medical and ancillary Providers with many having special expertise to care for the unique needs of its SNP Members including:

- Primary Care Providers – Internal Medicine, Family Medicine, Geriatric
- Medical Specialists (all medical specialties) including specifically Orthopedics, Neurology, Physical Medicine and Rehabilitation, Cardiology, Gastroenterology, Pulmonology, Nephrology, Rheumatology, Radiology and General Surgery.
- Mental/Behavioral Health Providers – Psychiatry, clinical psychology, Masters or above level licensed clinical social work, certified substance abuse specialist.
- Ancillary Providers – Physical therapists, occupational therapists, speech/ language pathology, chiropractic, podiatry.
- Nursing professionals – Registered nurses, nurse providers, nurse educators.

Molina determines Provider and facility licensure and competence through the credentialing process. Molina has a rigorous credentialing process for all Providers and facilities that must be passed in order to join the Molina Medicare SNP Network. The Molina Credentialing Team gathers information and performs primary source verification (when appropriate) of training, active licensure, board certification, appropriate facility accreditation (JCAHO or state), malpractice coverage, malpractice history (National Practitioner Provider Data Bank reports), Medicare opt out status, Medicare/Medicaid sanctions, state licensure sanctions.

After credentialing information file is complete and primary source verification obtained the Provider or facility is presented to the Molina Professional Review Committee (PRC). The PRC consists of Molina Network physicians who are in active practice as well as Molina Medical Directors. The PRC decides on granting network participation status to Providers who have gone through the credentialing process based on criteria including active licensure, board certification (may be waived to assure Member access when there is geographic need or access problems), freedom from sanctions and freedom from an excessive malpractice case history. Providers and facilities that have passed initial credentialing must go through a re-credentialing process every three (3) years utilizing the same criteria as the initial credentialing process. In addition the PRC performs ongoing monitoring for licensure status, sanctions, Medicare opt out status, Member complaint reports and peer review actions on a monthly basis (or quarterly for some reporting).

The Member's PCP is primarily responsible for determining what medical services a Member needs. For Members receiving treatment primarily through specialist physician, the specialist may be primarily responsible for determining needed medical services. The PCP is assisted by the Molina Care Management Team, medical specialty consultants, ancillary Providers, mental/behavioral health Providers and Members or their caregivers in making these determinations. For Members undergoing transitions in health care settings, facility staff (hospital, SNF, home health, etc.) may also be involved in making recommendations or assisting with access to needed services. For those services that require prior authorization the Molina Care Management Team will assist Providers and Members in determining medical necessity, available network resources (and out of network resources where necessary). The Molina Care Management portion of the ICT will assist in finding access when difficulties arise for certain services.

A primary way that the Molina Provider Network coordinates with the ICT is via the Molina Medicare SNP Prior Authorization process. Molina's Medicare SNP Prior Authorization requirements have been designed to identify Members who are experiencing transitions in health care settings or have complex or unresolved health care needs. Molina Members undergoing transitions in health care settings or experiencing complex or unresolved health care issues usually require services that are prior authorized. This allows Members of the ICT to be made aware of the need for services and any changes in the Member's health status. Part of the process includes obtaining medical records and documenting in QNXT so that the ICT can track those changes. The

Provider network will also communicate with the ICT when invited to attend ICT meetings, on an as needed basis by contacting the PCP or the Molina Care Management Team. Molina's electronic fax system allows for the transition of information from one Provider to another during transitions. Hospital inpatient information is provided to the PCP and/or treating Provider.

The Molina Medicare SNP will assure that specialized services are delivered in a timely and quality way by the following:

- Assuring that services requiring prior authorization are processed and that notification is sent as soon as required by the Member's health but no later than timelines outlined in CMS regulations.
- Directing care to credentialed network Providers when appropriate.
- Monitoring access to care reports and grievance reports regarding timely or quality care.

Reports on services delivered will be maintained by the ICT primarily in the PCP medical record. The Molina Medicare SNP regularly audits the completeness of PCP medical records utilizing the annual PCP Medical Record Review process. The Molina Care Management Team will document relevant clinical notes on services and outcomes in QNXT and Clinical Care Advance platforms as appropriate to document significant changes in the Member's health care status or health care setting and to update care plans. A copy of the care plan will be provided to the PCP.

The Molina Medicare SNP ICT will be responsible for coordinating service delivery across care settings and Providers. The Member's assigned PCP will be responsible for initiating most transitions of care settings (e.g., hospital or SNF admissions) and referrals to specialty or ancillary Providers. The Molina Care Management Team will assist specifically with Prior Authorization, access issues and coordinating movement from one care setting to the next when Members experience a change in their health care status (e.g., hospital discharge planning).

The Molina Medicare SNP will use nationally recognized, evidence based clinical practice guidelines. Molina Medical Directors will select clinical practice guidelines that are relevant to the SNP population. These clinical practice guidelines will be communicated to Providers utilizing Provider newsletter and the Molina website. Molina will annually measure Provider compliance with important aspects of the clinical practice guidelines and report results to Providers.

11. Model of Care Training - The Molina Medicare SNP will provide initial and annual SNP Model of Care training to all employed and contracted personnel. Web based or in person Model of Care training will be offered initially to all Molina employees who have not completed such training and to all new employees. Verification of employee training will be through attendance logs for in person training or certificate of completion of web based training program.

All Molina Providers have access to SNP Model of Care training via the Molina website. Providers may also participate in webinar or in person training sessions on the SNP Model of Care. Molina will issue a written request to Providers to participate in Model of Care training. Due to the very large community based network of Providers and their participation in multiple Medicare SNPs it is anticipated that many Providers will not accept the invitation to complete training. The Molina Provider Services Department will identify key groups that have large numbers of Molina's Medicare SNP Members and will conduct specific in person trainings with those groups. The development of model of care training materials will be the responsibility of a designated Molina Services Program Director or Medical Director. Implementation and oversight of completion of training will be the responsibility of a designated Molina Compliance staff (employees) and a designated Molina Provider Services staff (Providers). Employees will be required to complete training or undergo disciplinary action in accordance with Molina policies on completion of required training.

12. **Communication** - Molina will monitor and coordinate care for Members using an integrated communication system between Members/caregivers, the Molina ICT, other Molina staff, Providers and CMS. Communications structure includes the following elements:

    a. Molina utilizes state of the art telephonic communications systems for telephonic interaction between Molina staff and all other stakeholders with capabilities for call center queues, call center reporting, computer screen sharing (available only to Molina staff) and audio conferencing. Molina maintains Member and Provider services call centers during CMS mandated business hours and a Nurse Advice Line (after hours) that Members and Providers may use for communication and inquiries. Interactive voice response systems may be used for Member assessment data gathering as well as general health care reminders. Electronic fax capability and Molina's ePortal allow for the electronic transmission of data for authorization purposes and transitions between settings. Faxed and electronic information is maintained in the Member's Molina record.

    b. For communication of a general nature Molina uses newsletters (Provider and Member), the Molina website and blast fax communications (Providers only). Molina may also use secure web based interfaces for Member assessment, staff training, Provider inquiries and Provider training.

    c. For communication between Members of the ICT, Molina has available audio conferencing and audio video conferencing (Molina staff only). Most regular and ad-hoc ICT care management meetings will be held on a face-to-face basis with PCPs, other Providers and Member/caregivers joining via audio conferencing as needed.

    d. Written and fax documentation from Members and Providers (clinical records, appeals, grievances) when received will be routed through secure mail room procedures to appropriate parties for tracking and resolution.

e. Email communication may be exchanged with Providers and CMS.

f. Direct person-to-person communication may also occur between various stakeholders and Molina.

g. Molina Quality Improvement Committees and Sub-Committees will meet regularly on a face-to-face basis with Committee Members not able to attend in person attending via audio conferencing.

Tracking and documentation of communications occurs utilizing the following:

a. The QNXT call tracking system will be used to document all significant telephonic conversations regarding inquiries from Members/caregivers and Providers. All telephonically received grievances will be documented in the QNXT call tracking system. QNXT call tracking allows storage of a record of inquiries and grievances, status reporting and outcomes reporting.

b. Communication between ICT Members and/or stakeholders will be documented in QNXT call tracking, QNXT clinical modules or Case Management documentation electronic platform as appropriate. This documentation allows electronic status tracking and archiving of discussions. Written meeting summaries may be used when issues discussed are not easily documented using the electronic means documented above.

c. Written and faxed communications when received are stored in an electronic document storage solution and archived to preserve the data. Written documents related to appeals and grievances result in a call tracking entry made in QNXT call tracking when they are received allowing electronic tracking of status and resolution.

d. Email communication with stakeholders is archived in the Molina email server.

e. Direct person-to-person communication will result in a QNXT call tracking entry or a written summary depending on the situation.

f. Molina Committee meetings will result in official meeting minutes which will be archived for future reference.

A designated Molina Quality Improvement Director will have responsibility to oversee, monitor and evaluate the effectiveness of the Molina Medicare SNP Communication Program.

13. Performance and Health Outcomes Measurement - Molina collects, analyzes reports and acts on data evaluating the Model of Care. To evaluate the Model of Care, Molina may collect data from multiple sources including:

a. Administrative (demographics, call center data)

b. Authorizations
c. CAHPS®
d. Call Tracking
e. Claims
f. Clinical Care Advance (Care/Case/Disease Management Program data)
g. Encounters
h. HEDIS®
i. HOS
j. Medical Record Reviews
k. Pharmacy
l. Provider Access Survey
m. Provider Satisfaction Survey
n. Risk Assessments
o. Utilization
p. Chronic Disease Self-Management Plan (CDSMP) Assessment Results
q. Case Management Satisfaction Survey

Molina will use internal Quality Improvement Specialists, External Survey Vendors and Healthcare Analysts to collect analyze and report on the above data using manual and electronic analysis. Data analyzed and reported on will demonstrate the following:

a. Improved Member access to services and benefits.
b. Improved health status.
c. Adequate service delivery processes.
d. Use of evidence based clinical practice guidelines for management of chronic conditions.
e. Participation by Members/caregivers and ICT Members in care planning.
f. Utilization of supplementary benefits.
g. Member use of communication mechanisms.
h. Satisfaction with Molina's Case Management Program.

Molina will submit CMS required public reporting data including:

a. HEDIS® Data
b. SNP Structure and Process Measures
c. Health Outcomes Survey
d. CAHPS® Survey

Molina will submit CMS required reporting data including some of the following:

a. Audits of health information for accuracy and appropriateness.
b. Member/caregiver education for frequency and appropriateness.
c. Clinical outcomes.
d. Mental/Behavioral health/psychiatric services utilization rates.
e. Complaints, grievances, services and benefits denials.
f. Disease management indicators.
g. Disease management referrals for timeliness and appropriateness.
h. Emergency room utilization rates.

i. Enrollment/disenrollment rates.
j. Evidence-based clinical guidelines or protocols utilization rates.
k. Fall and injury occurrences.
l. Facilitation of Member developing advance directives/health proxy.
m. Functional/ADLs status/deficits.
n. Home meal delivery service utilization rates.
o. Hospice referral and utilization rates.
p. Hospital admissions/readmissions.
q. Hospital discharge outreach and follow-up rates.
r. Immunization rates.
s. Medication compliance/utilization rates.
t. Medication errors/adverse drug events.
u. Medication therapy management effectiveness.
v. Mortality reviews.
w. Pain and symptoms management effectiveness.
x. Policies and procedures for effectiveness and staff compliance.
y. Preventive programs utilization rates (e.g., smoking cessation).
z. Preventive screening rates.
aa. Primary care visit utilization rates.
bb. Satisfaction surveys for Members/caregivers.
cc. Satisfaction surveys for Provider network.
dd. Screening for depression and drug/alcohol abuse.
ee. Screening for elder/physical/sexual abuse.
ff. Skilled nursing facility placement/readmission rates.
gg. Skilled nursing facility level of care Members living in the community having admissions/readmissions to skilled nursing facilities.
hh. Urinary incontinence rates.
ii. Wellness program utilization rates.

Molina will use the above data collection, analysis and reporting to develop a comprehensive evaluation of the effectiveness of the Molina Model of Care. The evaluation will include identifying and acting on opportunities to improve the program. A designated Molina Quality Improvement Director and/or Medical Director will have responsibility for monitoring and evaluating the Molina SNP Model of Care. Molina will notify stakeholders of improvements to the Model of Care by posting the Model of Care Evaluation on its website.

14. Care Management for the Most Vulnerable Subpopulations - The Molina SNP will identify vulnerable sub-populations including frail/disabled, multiple chronic conditions, End Stage Renal Disease (ESRD) and those nearing end of life by the following mechanisms:

a. Risk assessments;
b. Home visits;
c. Predictive modeling;
d. Claims data;

e. Pharmacy data;
f. Care/case/disease management activities;
g. Self-referrals by Members/caregivers;
h. Referrals from Member Services; and/or,
i. Referrals from Providers.

Specific add-on services of most use to vulnerable sub-populations include:
a. Case management;
b. Disease management; and/or,
c. Provider home visits.

The needs of the most vulnerable population will be met within the Molina SNP Model of Care by early identification and higher stratification/priority in Molina programs including Disease Management and Case Management. These Members will be managed more aggressively and more frequently by the ICT. This will assure that they are receiving all necessary services and that they have adequate care plans before, during and after transitions in health care settings or changes in health care status.

8. Long Term Care and Services

Molina Duals Options 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

Molina Duals Options program available to members provides seamless 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.

A. CBAS

CBAS is a community-based day health program for older adults and adults with chronic medical, cognitive or mental health conditions, or disabilities who are at risk of needing institutional care. This program used to be called Adult Day Health Care (ADHC) and on October 1, 2012 it became a Medi-Cal Managed Care benefit. Medi-Cal Members eligible for CBAS, including dual eligible beneficiaries, must enroll in a managed care health plan to receive these services.

CBAS services allow Members to receive nursing and social services, therapies, personal attendant services, family/caregiver training and support, meals, and case management in one central location. Additional services such as physical therapy, occupational therapy, speech therapy, mental health services, registered dietitian services and transportation may be available to Members based on their Individualized Care Plans.

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 (2) or more of the following activities of daily living: bathing, dressing, self-feeding, toileting, ambulation, transferring, money management, accessing resources, meal preparation or transportation.

What services are included in CBAS?

Members may receive the following core services:
- Professional nursing.
- Social and/or personal care.
- Therapeutic activities.
- One (1) meal offered per day.

Molina case managers will work closely with CBAS centers and staff to expedite evaluation/access to services. Members may also receive any of the following additional services as specified in his/her Individualized Care Plan:
- Physical therapy
- Occupational therapy
- Speech therapy
- Mental health services
- Registered dietitian services
- Transportation to/from CBAS center and place of residence

How to refer Members in need of CBAS services:
- 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: (844) 557-8434 or Member Services Department at (855) 665-4627.

B. IHSS

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 as a Medi-Cal benefit, and Molina Healthcare of California coordinates IHSS benefits for eligible enrollees through county IHSS agencies. IHSS consumers' continue to 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.

What services are included in IHSS?

- 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

What is Self-Directed Care?

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 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 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 (855) 665-4627 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.

- San Diego County (Dept. of Health & Human Services): (800) 339-4661
- Riverside County (Dept. of Public Social Services): (888) 960-4477
- San Bernardino County (Dept. of Human Services): (877) 800-4544
- Los Angeles County (Dept. of Public Social Services): (888) 944-4477

C. MSSP

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.

Molina 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.

What services are included in MSSP?

- Adult day care
- Housing assistance
- Chore and personal care assistance
- Protective supervision
- Care management
- Respite
- Transportation
- Meal services
- Social services
- Communications services

How to refer Molina Members in need of MSSP Services:

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 contact 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 services.

Case Management Process

If the Member is determined to be eligible for program referral to MSSP, MHC 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.

D. Long Term Care (LTC) /Skilled Nursing Facility (SNF)

LTC is the provision of medical, social, and personal care services (above the level of room and board) that are not available in the community and are needed regularly due to a mental or physical condition. LTC is generally provided in a facility-based setting such as a SNF.

Under current State policy, a beneficiary enrolled in a health plan is no longer dis-enrolled from that plan when a SNF stay exceeds two months. Under the CCI, the beneficiary remains enrolled in a Managed Care health plan. The plan will continue to pay for the SNF care and coordinate health care services for the beneficiary for the entire time they reside in a SNF.

Medi-Cal beneficiaries receiving SNF/LTC services must join a Managed Care health plan for their Medi-Cal benefits in CCI counties. SNFs will get paid by the Medi-Cal health plan at the same relevant reimbursement rate depending on whether the stay is a Medicare or Medi-Cal benefit.

E. Behavioral Health and Substance Use Services

Mental and emotional well-being is essential to overall health. Sound mental health allows people to realize their full potential, live more independent lives, and make meaningful contributions to their communities. Reducing the stigma associated with mental health diagnoses is important to utilization of effective mental health treatment. Identifying and integrating mental health needs into traditional health care, social service, community is particularly important.

The following benefits are available to Molina Duals Option Members and is a responsibility of the Health Plan:

- Mental health hospitalization
- Mental health outpatient services
- Psychotropic Drugs
- Mental health services within the scope of primary care physician
- Psychologists
- Psychiatrists

Medi-Cal specialty mental health services are available through the county mental health plan (MHP) if the Member meets Medi-Cal specialty mental health services medical necessity criteria, including:

- Mental health services (assessment, therapy, rehabilitation, collateral, and plan development)
- Medication support services
- Day treatment intensive
- Day rehabilitation

- Crisis intervention and stabilization
- Adult residential treatment services
- Crisis residential treatment services
- Psychiatric health facility services
- Psychiatric inpatient hospital services
- Targeted case management

For Crisis Prevention and Behavioral Health Emergencies please contact our Nurse Advice Line available 24 hours a day, 7 days a week at (888) 275-8750 / TTY: 711.

For Molina Duals Option Members requiring Mental Health/Behavioral Health services or to make a referral, please note the following:

- Refer to Molina Prior Authorization requirements.
  - Behavioral health participating Providers should fax the Molina Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form to Molina as soon as possible, prior to the 20th outpatient visit, for outpatient treatment to (866) 472-0596.
  - If the request is for inpatient behavioral health, Partial Hospitalization or Intensive Outpatient Program for psychiatric or substance use disorders, the Molina Healthcare Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form should be faxed as soon as possible to the same number at (866) 472-0596. If the admission is an emergency, the form should be faxed as soon as possible to (866) 472-0596.
  - For non-participating Molina Providers, the form should be faxed prior to initiating treatment, unless for an emergency psychiatric admission. If the admission is an emergency, the form should be faxed as soon as possible to (866) 472-0596.
  - Molina Behavioral Health RN may call the behavioral health Provider for additional clinical information, particularly if the Molina Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form is not completely filled out.

For Substance Use Disorder (SUD) Treatment and Services, Molina adheres to Title 22, California Code of Regulations Section 51303, for covered services when determined to be medically necessary and coordinates with county alcohol and substance abuse services for applicable services. Molina provides inpatient medical detoxification and alcohol misuse counseling and refers to the respective County Alcohol and Drug Services for day care rehabilitation (for pregnant women, substance use disorders), outpatient individual and group counseling (substance use disorders), and methadone maintenance therapy.

For any questions, please contact Molina Member Services at (800) 526-8196.

9. Members' Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Evidence of Coverage (EOC). The EOC that is provided to Members annually is hereby incorporated into this Provider Manual.

State and Federal Law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care, and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact Molina at (855) 665-4627 Monday through Friday, 8:00 a.m. to 8:00 p.m., local time. TTY/TDD users, please call 711.

Second Opinions

If a Member does not agree with the Provider's plan of care, the Member has the right to request, at no cost, a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

10. Provider Responsibilities

Nondiscrimination of Health Care Service Delivery

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

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 with Medicare cost sharing from a State Medicaid Program.

Section 1557 Investigations

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

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

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

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

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

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

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

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing (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 (Provider Portal).

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

Any Provider insisting on paper claims submission and payment via paper check could be ineligible for Contracted Provider status within the Molina network.

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

If a Provider does not comply with Molina's Electronic Solution Requirements, the Provider's claim will be denied.

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

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

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

Electronic Payment (EFT/ERA) Requirement

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

Below is the link to register with Change Healthcare Provider Net 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 Web Portal

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

- Verify and print member eligibility – As well as view benefits, covered services and Member Health record.
- Member Roster – View a list of assigned membership 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/Authorization 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 benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers may not charge Members fees for covered services beyond copayments or coinsurance.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts. Balance billing a Medicare and/or Medicaid Member for Medicare and/or Medicaid covered services is prohibited by Law. 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 Claims and Compensation and the Compliance sections of this Provider Manual.

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 Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Member materials (such as Member Evidence of Coverage documents). A link to these rights and responsibilities is available in the Member Rights and Responsibilities section of this Provider Manual.

Member Eligibility Verification

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

Possession of a Molina Dual Options ID Card does not guarantee Member eligibility or coverage. A Provider must verify a recipient's eligibility each time the recipient presents to their

office for services. More information on Member eligibility verification options is available in the Eligibility, Enrollment, and Disenrollment section of this Manual.

Member Cost Share

Providers should verify the Molina Member's Cost Share status prior to requiring the Molina Member to pay co-pay, co-insurance, deductible or other Cost Share that may be applicable to the Member's specific Benefit Plan. Some plans have a total maximum Cost Share that frees the Member from any further out of pocket charges once reached (during that calendar year).

Healthcare Services (Utilization Management and Case Management)

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

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

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 Healthcare 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 (please refer to the Healthcare Services section of this Manual). 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 Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina Healthcare Dual Options. In the case of urgent and Emergency Services, Providers may direct Members to an 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.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to Molina.

Admissions

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

Participation in Utilization Review and Care Management Programs

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

Continuity and Coordination of Provider Communication

Molina stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers, and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings. Each year, we review feedback received from PCPs and specialists and facilities to determine if the level of satisfaction with the information provided across settings or between Providers is sufficient.

Treatment Alternatives and Communication with Members

Molina endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina promotes open discussion between Provider and

Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Pregnancy Notification Process

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

Maternal Mental Health Screening

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 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.

Prescriptions

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

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.

Participation in Quality Programs

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

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

Access to Care Standards

Molina is committed to providing timely access to care for all Members in a safe and healthy environment. Molina will ensure Providers offer hours of operation no less than offered to commercial Members. Access standards have been developed to ensure that all health care services are provided in a timely manner. The PCP or designee must be available twenty-four

(24) hours a day, seven (7) days a week to Members for Emergency Services. This access may be by telephone. For additional information about appointment access standards please refer to the Quality section of this Manual.

Site and Medical Record-Keeping Practice Reviews

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

Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record (electronic preferred or hard copy) should contain all information required by State and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina's policies and procedures. Providers are to retain all such records for a minimum of ten (10) years and retained further if the records are under review or audit until the review or audit is complete.

CMS has specific guidelines for the retention and disposal of Medicare records. Please refer to CMS General Information, Eligibility, and Entitlement Manual, Chapter 7, Chapter 30.30 for guidance.

Delivery of Patient Care Information

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

Compliance

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

Confidentiality of Member Protected Health Information (PHI) and HIPAA Transactions

Molina requires that 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. Please refer to the Compliance section of this Provider Manual for additional information.

Participation in Grievance and Appeals Programs

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

Please refer to the Complains, Grievance, and Appeals Process section of this Manual for additional information regarding this program.

Participation in Credentialing

Providers are required to participate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable accreditation state and federal requirements. This includes providing prompt responses to 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. When this notification is received, a site review of the new office may be conducted before the Provider's recredentialing date.

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. Please see the Delegation section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

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 400
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 500
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.

MolinaHealthcare.com

11. Cultural Competency and Linguistic Services

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency and Members who are deaf, hard of hearing, 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 Molina 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). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. 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.

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 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 staffs, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina which integrates Cultural Competency training into the overall Provider training and quality monitoring programs. An integrated quality approach intends to enhance the way people think about our Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

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

Training modules, delivered through a variety of methods, include:
1. Written materials;
2. On-site cultural competency training
3. Online cultural competency provider training; and
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications.

Integrated Quality Improvement – Ensuring Access

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

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats, 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:
  - Identification of significant culturally and linguistically diverse populations within plan's membership.
  - Revalidate data at least annually.
  - Provider Services to assess gaps in network demographics.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Needs Assessment)
- Applicable national demographics and trends derived from publicly available sources.
- Network Assessment.
- Collection of data and reporting for the Diversity of Membership HEDIS measure.
- Annual determination of threshold languages 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 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 2010.

24-Hour Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at (855) 665-4627. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service Provider.

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. It is never permissible to ask a family member, friend or minor to interpret.

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. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. 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 notification 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 Improvement, Healthcare Services and all other health plan functions.

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

Molina will provide face-to-face interpreter services for sign language interpretation to support our Members who are deaf or hard of hearing. Requests should be made three (3) days in advance of an appointment to ensure availability of the service. Call our Member & Provider Contact Center toll free at (855) 665-4627 to arrange for this service.

Nurse Advice Line

Molina provides twenty-four (24) hours/seven (7) days a week Nurse Advice Services for Members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina's Nurse Advice Line directly (English line [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.

12. Claims and Compensation

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

- Hospital Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Timely Claim Filing
- Claim Edit Process
- Claim Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Claim Payment
- Overpayment and Incorrect Payment
- 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
    e. Burn
    f. Other Injuries
6. Manifestations of Poor Glycemic Control

a. Hypoglycemic Coma
b. Diabetic Ketoacidosis
c. Non-ketotic Hyperosmolar Coma
d. Secondary Diabetes with Ketoacidosis
e. Secondary Diabetes with Hyperosmolarity

7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures:
    a. Spine
    b. Neck
    c. Shoulder
    d. Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity:
    a. Laparoscopic Gastric Restrictive Surgery
    b. Laparoscopic gastric bypass
    c. Gastroenterostomy
12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Iatrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a. Total Knee Replacement
    b. Hip Replacement

What this means to Providers:

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

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: http://www.cms.hhs.gov/HospitalAcqCond/

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or Molina's Provider Portal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 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.

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

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 for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI).
- Rendering Provider as applicable.
- Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim; 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 requires Participating Providers to submit Claims electronically. Electronic Claims submission provides significant benefits to the Provider including:
- Helps to reduce operation costs associated with paper claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces Claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and Claims reach Molina faster.

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina 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 (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 bring submitted to our gateway is received properly your submitter must utilize the latest version of the 837 standard. 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

Paper claims generally are not accepted by Molina. Claims submitted via paper could be denied. Electronic claims should be submitted rather than paper claims. Please refer to your contract for more information.

Coordination of Benefits and Third Party Liability (Medicare)

For Members enrolled in a Molina plan, Molina and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these Members. Molina will pay claims for covered services; however if COB/TPL is determined Molina may cost avoid if appropriate or request recovery post payment. Molina will attempt to recover any overpayments paid as the primary payer when another insurance is primary.

Medicaid Coverage for Molina Medicare Members (Medicare)

There are certain benefits that will not be covered by Molina Medicare program but may be covered by **fee-for-service Medicaid**. In this case, the Provider should bill Medicaid with a copy of the Molina Medicare remittance advice and the associated state agency will process the claim accordingly.

After exhausting all other primary coverage benefits, Providers may submit claims to Molina Medicare. A copy of the remittance advice from the primary payer must accompany the claim or the claim will be denied. If the primary insurance paid more than Molina's contracted allowable rate the claim is considered paid in full and zero dollars will be applied to claim.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina, and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Medicaid claims for covered services rendered to Molina Members must be filed within one hundred and eighty (180) calendar days from the date of service. Medicare claims for covered services rendered to Molina Members must be filed within one (1) calendar year from the date of service. 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.

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.

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

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

Corrected Claims

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

A complete claim is a claim that has no defect, impropriety, lack of any required substantiating documentation as outlined in "Required Elements" above, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

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 as follows:

- Ninety-five percent (95%) of the monthly volume of non-contracted "clean" claims are to be adjudicated within thirty (30) calendar days of receipt.
- Ninety-five percent (95%) of the monthly volume of contracted claims are to be adjudicated within sixty (60) calendar days of receipt.
- Ninety-five percent (95%) of the monthly volume of non-clean non-contracted claims shall be paid or denied within sixty (60) calendar days of receipt.

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 Reconsideration

Providers disputing a Claim previously adjudicated must request such action within one-hundred-twenty (120) of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim reconsideration's 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:
Providers should submit the following documentation:

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

Forms may be submitted via secure email or mail.

Claims Reconsideration requested via the CRRF may be sent to the following address:
Molina Healthcare of California, Inc.
Attention: Claims Disputes/Adjustments
200 Oceangate Suite 100
Long Beach CA 90802

Requests for claim redetermination should be sent via email to:
MedicareSpecialProjects@MolinaHealthcare.com

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.

Billing the Member

- Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party

- Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
  - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
  - The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.
  - The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Fraud and Abuse

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

Encounter Data

Each capitated Provider/organization delegated for Claims processing is required to submit Encounter data to Molina for all adjudicated Claims. 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 forty-five (45) days of the end of the month in which care was rendered, 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 shall have a comprehensive automated and integrated Encounter data system capable of meeting these requirements.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within fifteen (15) days from the rejection/denial.

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

When your Encounters are filed electronically you should receive:
- For any direct submission to Molina you should receive a 999 acknowledgement of your transmission.
- For Encounter submission you will also receive a 277CA response file for each Transaction.

13. Compliance

Fraud, Waste and Abuse Program

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's 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 and 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

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 detect, 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, including the Medicare and Medicaid programs. 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 Deficit Reduction Act (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 five (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; and,
- Employee protection rights as whistleblowers.

The Federal False Claims Act and state Medicaid False Claims Acts 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 (2) times the amount of back pay plus interest; and,
- 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 payments until compliance is met. Molina will take steps to monitor Molina 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. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g., coding) causing unnecessary costs to the Medicare program.

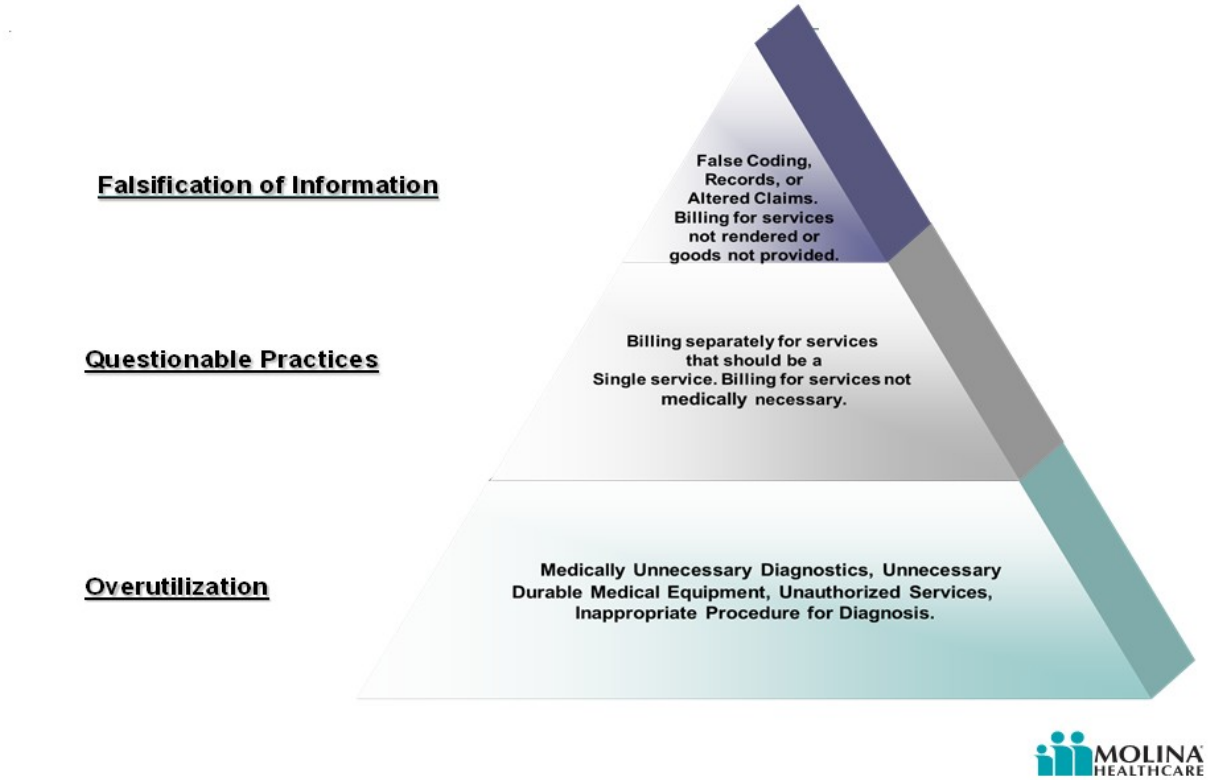
Abuse: Means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicare program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicare 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 Claim forms, electronic claim forms, and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a 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 Medicare and/or Medicaid benefits.

- Conspiracy to defraud Medicare and/or 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.

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.

Review of Provider

The Credentialing Department is responsible for monitoring Providers through the various Government reports, including:

- Federal and State sanction reports.
- Federal and State lists of excluded individuals and entities including the State of California suspension/exclusion list.
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Medicare suspended and ineligible Provider list.
- Monthly review of State Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate Government entity. Upon receiving this information the documents are presented to the Credentialing Committee for review and potential action. The Credentialing staff will also present the list of physicians found on the sanctions report to the Compliance Committee for review and potential oversight of action.

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 education visit is appropriate.

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan to Molina addressing the issues identified and how it will cure these issues moving forward.

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 (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, Molina Member ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to: California Department of Health Care Services

Toll Free Phone: 1-800-822-6222

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

Confidential Reporting of Suspected Fraud, Waste, and Abuse
Molina utilizes several mechanisms to encourage anonymous, confidential and private, good faith reporting of instances of suspected fraud, waste, and abuse. Molina maintains confidential reporting mechanisms that Molina employees, members, and providers can use to report suspected fraud, waste, and abuse. The Molina Healthcare AlertLine is available 24/7 and can be reached at any time (day or night), over the weekend, or even on holidays. To report an issue by telephone, call toll-free at (866) 606-3889. To report an issue online, visit https://molinahealthcare.AlertLine.com. In addition to the Molina Healthcare AlertLine, employees may still report issues of concern directly to their supervisor, any Compliance official, or the Legal department.

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. A sample of Molina's privacy notice is enclosed at the end of this section.

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 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 event 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. 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; and,
    - Accreditation, licensing, and credentialing.

Importantly, this allows Providers to share PHI with Molina for our health care 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

[1] See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

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.

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 health care 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 health care Provider 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 health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical – is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care 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 health care 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 health care administrative activities. Molina Providers must submit claims and other transactions to Molina using electronic formats. Certain electronic transactions in health care 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 area 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

Providers 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. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters submitted to Molina.

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.

Authorization for the Use and Disclosure of Protected Health Information

Name of Member: _____ Member ID#: _____

Member Address: _____ Date of Birth: _____

City/State/Zip: _____ Telephone #: _____

I hereby authorize the use or disclosure of my protected health information as described below.

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

Molina Healthcare

2. Name of persons/organizations authorized to receive the protected health information:

3. Specific description of protected health information that may be used/disclosed:

4. The protected health information will be used/disclosed for the following purpose(s):

5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes____ No____

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment,

payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. If the purpose of this authorization is for MHC to determine eligibility before enrollment, the requests use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization, MHC reserves the right to deny enrollment or eligibility for benefits.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, MHC reserves the right to deny that health care.

9. I understand that I have a right to receive a copy of this authorization, if requested by me.

10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that:
    a) action has been taken in reliance on this authorization; or
    b) if this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.

11. I understand that the information I authorize a person or entity to receive may be no longer protected by federal law and regulations.

12. I understand that under California law, except as expressly authorized, the recipient of the information may not further disclose the information, unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.

13. This authorization expires on/upon* _____

**If no expiration date or event is specified above, this authorization will expire 12 months from the date signed below.*

Signature of Member or Member's Personal Representative	Date
Printed Name of Member or Member's Personal Representative	Relationship to Member or Representative's Authority to act for the Member, if applicable

A copy of this signed form will be provided to the member, if the authorization was sought by Molina Healthcare.

Effective July 1, 2015
Molina Authorization for the Use and Disclosure of PHI- California- English

14. Credentialing and Recredentialing

The purpose of the Credentialing Program is to assure the Molina Healthcare and its subsidiaries (Molina) networks 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.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification 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 of Quality Assurance © (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Definitions

Rental/Leased Network – a network of Providers that leases its panel to another network or insurer with an emphasis on expanding Provider access and negotiating discounted fee-for-service fees. This type of network is sometimes referred to as a brokerage-leased network or thought of as "wholesale," since Members' access to the network is through an intermediary.

Primary Care Provider (PCP) – a Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to Pediatricians, Family Providers, General Providers or Internists, as designated by Molina.

General Practitioner – Physicians who are not Board Certified and have not completed a training program from an accredited training program in their requested specialty.

Urgent Care Provider (UCP) – a Provider who is not a PCP and only provides urgent care services to Members. Urgent care services are medically necessary services, which are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours. A UCP may include PA, NP, MD and DO. The UCP is usually trained in general practice, internal medicine, family medicine, pediatrics, or emergency medicine. Some UCPs may also have specialty training.

Primary Source verification –the process by which Molina verifies credentialing information directly from the entity that originally conferred or issued the credential to the Provider.

Locum Tenens – a substitute physician used to fill in for a regular physician for reasons such as illness, pregnancy, vacation, or continuing medical education. The regular physician bills and receives payment for the substitute physician as though he/she performed them. The substitute

physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee.

Physician – is a Doctor of Medicine (MD) or Doctor of Osteopathy (DO)

Unprofessional conduct – refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct, which is reasonably likely to be detrimental to Patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina plan.

Type of Practitioners Credentialed & Recredentialed

Practitioners and groups of practitioners with whom Molina contracts must be credentialed prior to the contract being implemented. These practitioners must be licensed, certified or registered by the state to practice independently.
Providers that are licensed as organizations or facilities will be credentialed as an Organizational Provider (please refer to the policy titled Assessment of Organizational Providers).
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
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- 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

- Psychologist
- Speech and Language Pathologists

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 Providers for participation in the Molina network. 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 Providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina. These criteria and the sources used to verify these criteria are listed in the table below.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Providers 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 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.

Providers must meet the following criteria to be eligible to participate in the Molina network. If the Provider fails to meet/provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

Burden of Proof

The Provider shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina network. This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a Provider without limitation, including physical and mental health status as allowed by Law, and the burden of resolving any doubts about these or any other qualifications to participate in the Molina network. If the Provider fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Providers who fail to provide this burden of proof do not have the right to submit an appeal.

Provider Termination and Reinstatement

If a Provider's contract is terminated and later it is determined to reinstate the Provider, the Provider must be initially credentialed prior to reinstatement, if there is a break in service more than thirty (30) calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Professional

Review Committee's review must be re-verified. The Professional Review Committee's or medical director, as appropriate, must review all credentials and make a final determination prior to the Provider's reentry into the network. Not all elements require re-verification; for example, graduation from medical school or residency completion does not change. If the contract termination was administrative only and not for cause, if the break in service is less than thirty (30) calendar days, the Provider can be reinstated without being initially credentialed.

If Molina is unable to recredential a Provider within thirty-six (36) months because the Provider is on active military assignment, maternity leave or sabbatical, but the contract between Molina and the Provider remains in place, Molina will recredential the Provider upon his or her return. Molina will document the reason for the delay in the Provider's file. At a minimum, Molina will verify that a Provider who returns has a valid license to practice before he or she can resume seeing Patients. Within sixty (60) calendar days of notice, when the Provider resumes practice, Molina will complete the recredentialing cycle. If either party terminates their contract and there was a break in service for more than thirty (30) calendar days, Molina will initially credential the Provider before the Provider rejoins the network.

Credentialing Application

At the time of initial credentialing and recredentialing, the Provider must complete a credentialing application designed to provide Molina with information necessary to perform a comprehensive review of the Provider's credentials. The application must be completed in its entirety. The Provider must attest that their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. The application must include, unless State law requires otherwise:

- Reason for any inability to perform the essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- History of loss of license and felony convictions;
- History of loss or limitation of privileges or disciplinary action;
- Current malpractice insurance coverage; and,
- The correctness and completeness of the application.

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 or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the Provider specializes. This does not preclude Molina from including in its network Providers who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Notification of Discrepancies in Credentialing Information

Molina will notify the Provider 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, malpractice claims history or sanctions. 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. Please also refer to the section below titled 'Providers Right to Correct Erroneous Information'.

Notification of Credentialing Decisions

A letter is sent to every Provider with notification of the Professional Review Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within two weeks of the decision. Copies of the letters are filed in the Provider's credentials files. Under no circumstance will notification letters be sent to the Providers later than sixty (60) calendar days from the decision.

Providers Rights during the Credentialing Process

Providers have the right to review their credentials file at any time. Provider's rights are published in the online Provider Manual for them to review at any time. A copy of the Provider Manual is also sent to the Provider at the time of initial contracting.
The Provider 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 Provider 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 Provider are documents which the Provider sent to Molina (e.g., the application, the license and a copy of the DEA certificate). Providers may not copy documents that include pieces of information that are confidential in nature, such as the Provider credentialing checklist, the responses from monitoring organizations (i.e. National Provider Data Bank, State Licensing Board), and verification of hospital privileges letters.

Providers Right to Correct Erroneous Information

Providers have the right to correct erroneous information in their credentials file. Providers are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

Molina will notify the Provider 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. 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. The notification sent to the Provider will detail the information in question and will include instructions to the Provider indicating:

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina.
- In their response, the Provider must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The Provider's response must be sent to Molina Healthcare, Inc. Attention: Credentialing Director at PO Box 2470, Spokane, WA 99210.

Upon receipt of notification from the Provider, Molina will document receipt of the information in the Provider'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 Provider's credentials file. The Provider will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with Providers', the Credentialing Department will notify the Provider. The Provider may then provide proof of correction by the primary source body to Molina's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the Provider does not respond within ten (10) calendar days, their application processing will be discontinued and network participation will be administratively denied or terminated.

Providers Right to be Informed of Application Status

Providers have a right, upon request, to be informed of the status of their application. The Provider can request to be informed of the status of their application by telephone, email or mail. Molina will respond to the request within two working days. Molina may share with the Provider where the application is in the credentialing process to include any missing information or information not yet verified. Molina does not share with or allow a Provider to review references or recommendations, or other information that is peer-review protected.

Excluded 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.
- 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.

15. 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 14-004and 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 letter12-006, 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) designated critical access elements. The information provided must, at a minimum, display the level of access results met per Provider site as either Basic Access or Limited Access, and Medical Equipment (and/or Participant Area) Access. Basic Access demonstrates that a facility site provides access for Members with disabilities to parking, exterior building, interior building, exam room, restrooms, and medical equipment. Unlike the Facility Site Review and Medical Records Review, PARS is an assessment and no corrective action is required.

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

Exempted:

- 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

Conditional:

- A performance score of eighty percent 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 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 forty-five (45) 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 forty-five (45) calendar days from the date of the review.

Physicians with a Not Pass Score

A score of seventy-nine percent (79%) or below and survey deficiencies not corrected within the established CAP timeframes 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 ONE-HUNDRED-TWENTY (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 investigation that may include performing an unannounced facility site evaluation and subsequent 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 eighteen (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

16. 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 an appointment 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 provider's ability to meet Molina, State and Federal requirements for delegation of the function.

Sanction Monitoring

All sub-contractors of Molina are required to have processes to screen staff and employees at all levels against Federal exclusions 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 and CMS 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 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.

Credentialing

Credentialing functions may be delegated to entities which meet National Committee for Quality Assurance (NCQA) criteria for credentialing functions.

To be delegated for credentialing functions, Providers must at minimum:

- Pass Molina's credentialing pre-assessment, which is based on NCQA© credentialing standards.
- 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, exclusion lists a minimum of every thirty (30) days.
- 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 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 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 depend 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 and 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, the 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

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, the 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.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports determined by the function(s) delegated to the identified Molina Delegation Oversight Staff within the timeline indicated by the Health Plan. For a copy of Molina's current delegation reporting requirements, please contact your Molina Contract Manager.

Oversight Monitoring of Delegated Functions

Prior to approval of delegation, and at least annually thereafter, MHC conducts an onsite review of potential delegates 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 delegate's 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. Once approved for delegation, an "Acknowledgement Acceptance of Delegation" must be signed between MHC and the Delegated Entity. 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 Entity's 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 Entity demonstrates noncompliance to NCQA, contractual, State and Federal Requirements.
Complex Case Management services are not delegated. MHC's Medical Case Management Department retains sole responsibility for authorization and implementation of these services.

Delegated Entities 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.

17. Member Grievances and Appeals

Molina Members have the right to file and submit a grievance and/or appeal through a formal process. Members may elect a personal representative or a Provider to file the grievance or appeal on their behalf.

Complaints, Grievances and Appeals Process

1. **Complaints –** may be either grievances or appeals or both and may be processed under one or both procedures. The Appeals and Grievance Form can be completed by the Member or representative when filing and submitting a grievance or appeal.

   Each issue is adjudicated separately. **Complaints or disputes involving organization determinations are processed as appeals.** All other issues are processed as grievances. General guidelines that are used to determine the category of the complaint are:
   - The grievance process will be used for complaints concerning disenrollment, cost sharing, changes in premiums, and access to a Provider or Molina;
   - Changes in Provider availability to a specific Member will be considered an organization determination.
   - The QIO process is used for complaints regarding quality of medical care.

2. **Grievances** – Grievance procedures are as follows:
   - Molina will accept any information or evidence concerning the grievance orally or in writing not later than sixty (60) days after the event and will thoroughly investigate, track and process the grievance within thirty (30) days unless an extension is granted;
   - If Molina extends the time necessary or refuses to grant an organization determination or reconsideration Molina will respond to the Member within twenty-four (24) hours; and,
   - Complaints concerning the timely receipt of services already provided are considered grievances.

   Quality of Care – Molina Members have a right file a complaint regarding the care provided. Molina must respond to all Quality of Care complaints in writing to the Member. Molina monitors, manages, and improves the quality of clinical care and services received by its Members by investigating all issues including Serious Adverse Events, Hospital Acquired Conditions and Never Events. Members may also file care complaints with the State's contracted and CMS assigned Quality Improvement Organization.

3. Organization Determination

Organization Determinations are any determinations (an approval, modification or denial) made by Molina regarding payment or services to which a Member believes he/she is entitled such as

temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.

Molina's Utilization Management Department handles organization determination. Organization Determination is discussed in the Healthcare Services section of this Provider Manual. Any party to an organizational determination, e.g., a Member, a Member's representative or a non-contracted Provider, or a termination of services decision, may request that the determination be reconsidered.

Organization determinations are either standard or expedited depending on the urgency of the member's request.

Definition of Key Terms used in the Molina Healthcare Grievance and Appeal Process

The definitions that follow will clarify terms used by Molina for Member appeals and grievances. Following the definitions is a brief discussion of Molina grievance and appeal processes. Any questions on these polices should be directed to your Provider Services Representative.

Appeal	Any of the procedures that deal with the review of adverse organization determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by Molina and if necessary, an independent review entity, hearing before an Administrative Law Judge (ALJ), review by the Medicare Appeals Council (MAC), and judicial review.
Assignee	A non-contracted Provider who has furnished a service to the Member and formally agrees to waive any right to payment from the Member for that service.
Complaint	Any expression of dissatisfaction to Molina, Provider, facility or Quality Improvement Organization (QIO) by a Member made orally or in writing. This can include concerns about the operations of Providers or Molina such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to Members, the claims regarding the right of the Member to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the Member believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.
Coverage Determination:	A written denial notice by Molina that states the specific reasons for the denial and informs the Member of his or her right to reconsideration. The notice describes both the standard and expedited appeals processes and the

Denial Notices	rest of the appeals process. For payment denials, the notice describes the standard redetermination process and the rest of the appeals process.
Effectuation	Compliance with a reversal of Molina original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.
Member	A Medicare-eligible individual who has elected a Medicare plan offered by a Medicare Advantage organization, or a Medicare eligible individual who has elected a cost plan or HCPP.
Independent Review Entity	An independent entity contracted by CMS to review Molina's adverse reconsiderations of organization determinations.
Inquiry	Any oral or written request to Molina, Provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by a Member.
Medicare Plan	A plan defined in 42 CFR. 422.2 and described at 422.4.
Organization Determination	Any determination made by Molina with respect to any of the following: ▪ Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; ▪ Payment for any other health services furnished by a Provider other than a Molina Medicare Provider that the Member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Molina; ▪ Molina's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by the Medicare health plan; ▪ Discontinuation of a service if the Member believes that continuation of the services is medically necessary; and/or, ▪ Failure of Molina to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.
Quality Improvement Organization (QIO)	Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare Members. QIOs review complaints raised by Members about the quality of care provided by Providers, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Molina, and ambulatory surgical centers. The QIOs also review continued stay denials for Members receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.
Quality of Care Issue	A quality of care complaint may be filed through the Molina grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by Molina meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Reconsideration	A Member's first step in the appeal process after an adverse organization determination; Molina or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.
Representative	An individual appointed by a Member or other party, or authorized under State or other applicable Law, to act on behalf of a Member or other party involved in the appeal. Unless otherwise stated, the representative will have all of the rights and responsibilities of a Member or party in obtaining an organization determination or in dealing with any of the levels of the appeals process, subject to the applicable rules described in 42 CFR part 405.

Important Information about Member Appeal Rights

For information about Members' appeal rights, call the Molina Member Service Department, Monday through Friday, 8:00 a.m. to 8:00 p.m., toll free at (855) 665-4627 or 711 for persons with hearing impairments (TTY/TDD).

Below is information for Molina Members regarding their appeal rights. A detailed explanation of the appeal process is included in the Member's Evidence of Coverage (EOC) that has been provided to them. If Members have additional questions, please refer them to Molina Member Services.

There Are Two (2) Kinds of Appeals You Can File: Standard Appeal Thirty (30) days – You can ask for a standard appeal. Your plan must give you a decision no later than thirty (30) days after it gets your appeal. Your plan may extend this time by up to fourteen (14) days if you request an extension, or if it needs additional information and the extension benefits you. Expedited Seventy-two (72) hour review – You can request for an/expedited appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide an expedited appeal no later than seventy-two (72) hours after it receives your appeal. Your plan may extend this time by up to fourteen (14) days if you request an extension, or if it needs additional information and the extension benefits you.	**What do I include with my Appeal?** You should include your name, address, Member ID number, reason for appealing and any evidence you wish to attach. You may send in supporting medical records, Provider's letter(s), or other information that explains why your plan should provide service. Call your Provider if you need this information to help with your appeals. **How do I file an Appeal?** For Standard Appeal: you or your authorized representative can mail or deliver your written appeal to Molina Medicare at: Molina Medicare Attn: Grievance and Appeals P.O. Box 22816 Long Beach, CA 90801-9977 Hours of Operation:

If any Provider asks for a fast appeal for you, or supports you in asking for one, and the Provider indicates that waiting for thirty (30) days could seriously harm your health, your plan will automatically give you a fast appeal. If you ask for a fast appeal without support from your Provider, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal in thirty (30) days	Monday through Sunday 8:00 a.m. to 8:00 p.m. To file an oral appeal call us toll free: (855) 665-4627/ TTY number: 711 Fax Number (not toll free): (562) 499-0603 Other resources: Medicare Rights Center: Toll free: (888) HMO-9050 Toll free: (800) MEDICARE -(800)-633-4227) To file an oral grievance call us toll free: (855) 665-4627/TTY number: 711 Fax Number (not toll free): (562) 499-0603 Other resources: Medicare Rights Center: Toll free: (888) HMO-9050 Toll free: (800) MEDICARE (800) 633-4227 If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights toll free at (800) 368-1019 or TTY/TDD (800) 537-7697, or call your local Office for Civil Rights.

18. Medicare Part D

A Part D coverage determination is a decision about whether to provide or pay for a Part D drug, a decision concerning a tiering exception request, a formulary exception request, a decision on the amount of cost sharing for a drug, or whether a Member has or has not satisfied a prior authorization or other UM requirement.

Any party to a coverage determination, (e.g., a Member, a Member's representative, or a Member's prescriber) may request that the determination be appealed. A Member, a Member's representative, or Provider, are the only parties who may request that Molina expedite a coverage determination or redetermination.

Coverage determinations are either standard or expedited depending on the urgency of the Member's request.

Appeals/Redeterminations

When a Member's request for a coverage determination is denied, Members may choose someone (including an attorney or Provider) to serve as their personal representative to act on their behalf. After the date of the denial, a Member has up to sixty (60) days to request a redetermination. This is the first level of appeal for Part D adverse decisions. Appeal data is confidential.

The redetermination request will be responded to within seven (7) days. If an expedited appeal is required for an emergent situation, then the decision will be made within seventy- two (72) hours of the request.

At any time during the appeal process, the Member or personal representative may submit written comments, papers or other data about the appeal in person or in writing. If the appeal/reconsideration is denied, the Member has the right to send the appeal to the Independent Review Entity (IRE) within sixty (60) days of receipt of the appeal. The IRE has seven (7) days to make a decision for a standard appeal/reconsideration and seventy-two (72) hours for an expedited request. The IRE will notify Molina and the Member of the decision. When an expedited review is requested, the IRE will make a decision within seventy-two (72) hours.

If the IRE changes the Molina decision, authorization for service must be made within seventy-two (72) hours for standard appeals and within twenty-four (24) hours for expedited appeals.

Payment appeals must be paid within thirty (30) days from the date the plan receives notice of the reversal.

If the IRE upholds Molina's denial they will inform the Member of their right to a hearing with the ALJ and will describe the procedures that must be followed to obtain an ALJ hearing.

CMS's IRE monitors Molina's compliance with determinations to decisions that fully or partially reverse an original Molina denial. The IRE is currently Maximums Federal Services, Inc.

For Medicaid drugs, you have ninety (90) days from the date on the Notice of Action to file an appeal with Molina. You may file an appeal in person, in writing, by e-mail, fax, TTY, or telephone. All levels of the appeal procedures will be completed in thirty (30) calendar days. At any time within ninety (90) days of the date on the Notice of Action, you may request a State Fair Hearing by contacting the California Department of Social Services.

Part D Prescription Drug Exception Policy

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits a Member is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, a Member can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost UM tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

Molina is committed to providing access to medically necessary prescription drugs to Members of Molina. If a drug is prescribed that is not on Molina's formulary, the Member or Member's representative may file for an exception. All exceptions and appeals are handled at the plan level (on-site) and are not delegated to another entity. Please see below for contact information by plan for personnel who handle the exceptions. Members or the Member's representatives (who can include Providers and pharmacists) may call, write, fax, or e-mail Molina's exception contact person to request an exception. Procedures and forms to apply for an exception may be obtained from the contact persons.

Part D Exceptions and Appeals Contact Information: call toll free Molina at **(855) 665-4627 or fax (866) 290-1309**.

The Policy and Procedure for Exceptions and Appeals will be reviewed by a Pharmacy and Therapeutics (P&T) Committee on an annual basis at minimum. Exception / Prior Authorization criteria are also reviewed and approved by a P&T Committee.

1. **Formulary -** A formulary is a list of medications selected by Molina in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Molina will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Molina network pharmacy and other plan rules are followed.

Formularies may be different depending on the Molina Medicare Plan and will change over time. Current formularies for all products may be downloaded from our Website atwww.MolinaHealthcare.com.

2. **Copayments for Part D** - The amount a patient pays depends on which drug tier the drug is in under the plan and whether the patient fills the prescription at a preferred network pharmacy.
   - Most Part D services have a co-payment;
   - Co-payments cannot be waived by Molina per the Centers for Medicare & Medicaid Services; and,
   - Co-payments for Molina may differ by State and plan.

3. **Restrictions on Molina Medicare Drug Coverage**

   Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:
   - **Prior Authorization:** Molina requires prior authorization for certain drugs, some of which are on the formulary and also drugs that are not on the formulary. Without prior approval, Molina may not cover the drug;
   - **Quantity Limits:** For certain drugs, Molina limits the amount of the drug that it will cover;
   - **Step Therapy:** In some cases, Molina requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, Molina may not cover drug B unless drug A is tried first; and/or
   - **Part B Medications:** Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration. 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.

4. **Non-Covered Molina Medicare Medi-Cal Program/Cal MediConnect Part D Drugs:**
   - Agents when used for anorexia, weight loss, or weight gain (no mention of medically necessary);
   - Agents when used to promote fertility;
   - Agents used for cosmetic purposes or hair growth;
   - Prescription vitamins and minerals, except those used for prenatal care and fluoride preparations;
   - Non-prescription drugs, except those medications listed as part of Molina's Medicare over-the-counter (OTC) monthly benefit as applicable and depending on the plan;

- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale;
- Molina Members with Medicaid coverage may have a limited selection of these excluded medications as part of its Medicaid coverage for Members assigned to Molina Medicaid.
- Prescriptions that are not being used for a medically accepted indication (i.e., prescriptions must either be FDA-approved or compendia supported for the diagnosis for which they are being used; the Medicare-approved compendia are American Hospital Formulary Service Drug Information (AHFS) and DRUGDEX® Information System).

5. **There may be differences between the Medicare and Medicaid Formularies.** The Molina Formulary includes many injectable drugs not typically found in its Medicaid formularies such as those for the aged, blind and disabled.

6. **Requesting a Molina Medicare Formulary Exception -** Molina product drug prior authorizations are called Exceptions, which are required when your patient needs a drug that is not on the Formulary. A Member, a Member's appointed representative or a Member's prescribing Provider are permitted to file an Exception. (The process for filing an exception is predominantly a fax based system.) The form for exception requests is available on the Molina website: www.MolinaHealthcare.com.

7. **Requesting a Molina Formulary Redetermination (Appeal) -** The appeal process involves an adverse determination regarding Molina issuing a denial for a requested drug or claim payment. If the Member received a Notice of Denial of Medicare Prescription Drug Coverage and disagrees with the decision rendered, he/she may request a redetermination (appeal) from Molina by completing the appeal form sent with the Notice of Denial.

   A Member, a Member's appointed representative or a Member's prescribing Provider (for expedited appeals) may complete the appeal form and submit any information which may help Molina with the processing of the appeal. An appeal must be submitted in writing and filed within sixty (60) calendar days from the date that the determination was rendered.
   - A standard appeal may be submitted to Molina in writing or can be taken over the telephone. The appeal will be reviewed upon receipt and the Member will be notified in writing within seven (7) calendar days from the date the request for re-determination is received.
   - An expedited appeal can be requested orally or in writing by the Member or by a Provider acting on behalf of the Member. An expedited appeal may be requested in situations where applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum function. If a Provider supports the request for an expedited appeal, Molina will honor this request.

- If a Member submits an appeal without Provider support, Molina will review the request to determine if it meets Medicare's criteria for expedited processing. If the plan determines that the request meets the expedited criteria, Molina will render a decision as expeditiously as the Member's health requires, but not exceeding seventy-two (72) hours. If the request does not meet the expedited criteria, Molina will render a coverage decision within the standard redetermination time frame of seven (7) calendar days.
- To submit a verbal request, please call toll free (855) 665-4627. Written appeals must be mailed or faxed toll free (866) 290-1309.

8. Initiating a Part D Exception (Prior Authorization) Request - Molina will accept requests from Providers or a pharmacy on the behalf of the Member either by a written or verbal request. The request may be communicated through the standardized Molina Medication Prior Authorization Request Form or through telephone via fax and telephone lines. All requests will be determined and communicated to the Member and the Member's prescribing Provider with an approval or denial decision within seventy-two (72) hours/three (3) calendar days after Molina receives the completed request. All initial requests for Medicaid drugs will be reviewed within twenty-four (24) hours.

Molina will request submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by: 1) Molina Pharmacy Technician under the supervision of a pharmacist; 2) Molina Pharmacist; or, 3) Chief Medical Officer (CMO) of Molina. Review criteria will be made available at the request of the Member or his/her prescribing Provider. Molina will determine whether a specific off-label use is a medically accepted indication based on the following criteria:

a. A prescription drug is a Part D drug only if it is for a medically accepted indication, which is supported by one or more citations included or approved for inclusion with the following compendia:
   - American Hospital Formulary Service Drug Information; and,
   - DRUGDEX Information System.

b. Requests for off-label use of medications will need to be accompanied with excerpts from one (1) of the two (2) CMS-required compendia for consideration. The submitted excerpts must site a favorable recommendation.

c. Depending upon the prescribed medication, Molina may request the prescribing Provider to document and justify off-label use in clinical records and provide information such as diagnostic reports, chart notes, and medical summaries.

Denial decisions are only given to the Member or Member's representative by a Pharmacist or CMO of Molina. The written denial notice to the Member (and the prescriber involved) includes the specific rationale for denial; the explanation of both the standard and expedited appeals process; and, an explanation of a Member's right to, and conditions for, obtaining an expedited an appeals process.

If Molina denies coverage of the prescribed medication, Molina will give the Member a written notice within seventy-two (72) hours explaining the reason for the denial and how to initiate the appeals process. If no written notice is given to the Member within the specified timeframe, Molina will start the next level of appeal by sending the Coverage Determination request to the IRE within twenty-four (24) hours.

Denial decisions are only given to the Member or Member's representative by a Pharmacist or CMO of Molina. The written denial notice to the Member (and the prescriber involved) includes the specific rationale for denial; the explanation of both the standard and expedited appeals process; and an explanation of a Member's right to, and conditions for, obtaining an expedited an appeals process.

If Molina denies coverage of the prescribed medication, Molina will give the Member a written notice within seventy-two (72) hours explaining the reason for the denial and how to initiate the appeals process. If no written notice is given to the Member within the specified timeframe, Molina will start the next level of appeal by sending the Coverage Determination request to the Independent Review Entity (IRE) within twenty-four (24) hours.

If a coverage determination is expedited, Molina will notify the Member of the coverage determination decision within the twenty-four (24) hour timeframe by telephone and mail the Member a written Expedited Coverage Determination within three (3) calendar days of the oral notification. If Molina does not give the Member a written notification within the specified timeframe, Molina will start the next level of appeal by sending the Coverage Determination request to the Independent Review Entity (IRE) within twenty-four (24) hours.

9. **Initiating a Part D Appeal** - If Molina's initial coverage determination is unfavorable, a Member may request a first level of appeal, or re-determination within sixty (60) calendar days from the date of the notice of the coverage determination. In a Standard Appeal Molina has up to seven (7) days to make the re-determination, whether favorable or adverse, and notify the Member in writing within seven (7) calendar days from the date the request for re-determination is received. Members or a Member's prescribing Provider may request Molina to expedite a redetermination if the standard appeal timeframe of seven (7) days may seriously jeopardize the Member's life, health, or ability to regain maximum function. Molina has up to seventy-two (72) hours to make the re-determination, whether favorable or adverse, and notify the Member in writing within seventy-two (72) hours after receiving the request for re- determination. If additional information is needed for Molina to make a re- determination, Molina will request the necessary information within twenty- four (24) hours of the initial request for an expedited re-determination. Molina will inform the Member and prescribing Provider of the conditions for submitting the evidence since the timeframe is limited on expedited cases.

10. **The Part D Independent Review Entity (IRE) -** If the re-determination is unfavorable, a Member may request reconsideration by the IRE. The Part D Qualified Independent Contractor (IRE) is currently MAXIMUS Federal, a CMS contractor that provides second level appeals.
    - **Standard Appeal:** The IRE has up to seven (7) days to make the decision.
    - **Expedited Appeal:** The IRE has up to seventy-two (72) hours for to make the decision.
    - **Administrative Law Judge (ALJ):** If the IRE's reconsideration is unfavorable, a Member may request a hearing with an ALJ if the amount in controversy requirement is satisfied. **Note:** Regulatory timeframe is not applicable on this level of appeal.
    - **Medicare Appeals Council (MAC):** If the ALJ's finding is unfavorable, the Member may appeal to the MAC, an entity within the Department of Health and Human Services that reviews ALJ's decisions. Note: Regulatory timeframe is not applicable on this level of appeal.
    - **Federal District Court (FDC) -** If the MAC's decision is unfavorable, the Member may appeal to a Federal district court, if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable on this level of appeal.

19. Risk Adjustment Management Program

What is Risk Adjustment?

Risk Adjustment is a process that helps to accurately measure the health status of a plan's membership based on medical conditions and demographic information (age, gender, etc.)

Why is Risk Adjustment Important?

- Allows Molina to focus on quality and efficiency.
- Enables us to recognize and address current and potential health conditions early.
- Identifies members for Case Management referral.
- Ensures accurate payment for the acuity levels of our Members.
- Most importantly, Risk Adjustment allows Molina to have the resources to deliver the highest quality of care to our Members.

Your Role as a Provider

As a provider your documentation is critical to Risk Adjustment because medical records:

- Are a valuable source of diagnosis data.
- Help determine the ICD-10 codes that should be used.
- Ensure that diagnosis data submitted to State and Federal agencies is accurate.

For a complete and accurate medical record, all provider documentation must:

- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only submit codes for which the Provider is certain the Member has.
- Contain a treatment plan.
- Be clear and concise.
- Contain the Member's name and date of service.
- Contain the physician's signature and credentials.

RADV Audits

Part of the Risk Adjustment process includes CMS conducting Risk Adjustment Data Validation (RADV) audits to ensure that diagnosis data that was previously submitted by Molina was accurate for risk adjustment purposes. Therefore, all claims/encounters submitted to Molina are subject to federal audit or auditing by Molina. If Molina is selected for a RADV audit, Provider will be required to submit medical records to validate the data previously submitted.

Contact Information

For further questions about Molina's Risk Adjustment programs, please contact our team at: RiskAdjustment.Programs@MolinaHealthcare.com.

20. Glossary

Term	Definition
Appeal	A review by the MCP of 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.
Abuse	Practices that are inconsistent with sound fiscal, business, or medical practices, that result in an unnecessary cost to the government program or in reimbursement for services that are not medically necessary, or fail to meet professionally recognized standards for healthcare.
Case Management	A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to accommodate the specific health services needed by an individual.
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.
Claim	A request for payment for the provision of Covered Services prepared on a CMS1500 form, UB92, or successor.
CMS	Centers for Medicare and Medicaid Services
Co-insurance	The amount a Member pays for medical services after the deductible is paid. Coinsurance amounts are usually percentages of approved amounts.
Co-payment or Co-pay	The amount a Member pays for medical services such as a Provider's visit or prescription.
Deductible	The amount a Member pays for health care or prescriptions, before the health plan begins to pay.
Disenroll	Ending healthcare coverage with a health plan.
Division of Financial Responsibility (DOFR)	A document whereby health plans assign the payment risk for any contract, dividing payment responsibilities among the plan itself, the contracted hospital, or a Medical Group/IPA.
Durable Medical Equipment (DME)	Purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care Provider to be used in a patient's home.
Eligibility List	A list of Members that are assigned to Primary Care Providers (PCP) through a Medical Group, IPA or Staff Model Organization.
Emergency Services/Care	Care given for a medical emergency when a Member believes that his/her health is in serious danger when every second counts.
Encounter Data	Claims data for services rendered to Members who are assigned to a PCPs through a capitated Medical Group or IPA, or Staff Model Organization.

Term	Definition
Enrollment	The process by which an eligible person becomes a Member of a managed care plan.
EOB	Explanation of Benefits
Experimental	Items and procedures determined by Medicare not to be generally accepted by the medical community.
Formulary	A list of certain prescription drugs that the health plan will cover subject to limits and conditions.
Fraud	Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. This includes any act that constitutes fraud under applicable Federal or State law.
Grievance	A complaint about the way a Medicare health plan is giving care.
Health Maintenance Organization Plan	A type of Medicare Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. HMO costs may be lower than in the Original Medicare Plan.
Home Health Agency	An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.
Hospice Services	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling.
In-Home Supportive Services (IHSS)	A California program that provides in-home care for Members who cannot safely remain in their own homes without assistance.
Institution	A facility that meets Medicare's definition of a long-term care facility, such as a nursing home or skilled nursing facility. Assisted or adult living facilities, or residential homes, are not included.
IPA (Independent Practice Association)	An IPA is an association of Providers and other health care Providers, including hospitals, who contract with HMOs to provide services to the HMO Members, but usually also see non-HMO patients.
Long-Term Service and Support (LTSS)	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term service and support can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare does not pay for this type of care if this is the only care needed.
Managed Care	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most

Term	Definition
	long-term care is custodial care. Medicare does not pay for this type of care if this is the only care needed.
Medicaid	A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most healthcare costs are covered if a Member qualifies for both Medicare and Medicaid.
Medically Necessary	Refers to a covered service or treatment that is absolutely necessary to protect and enhance the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice.
Member	A Medicare-eligible individual who is eligible and enrolled in a Molina Medicare health plan.
Multi-Purpose Senior Services Program (MSSP)	A program that 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.
Network	A group of doctors, hospitals, pharmacies, and other healthcare experts hired by a health plan to take care of its Members.
Participating Provider	Participating Providers agree to accept a pre-established approved amount as payment in full for service. Provider is used as a global term to include all types of Providers
Primary Care Provider (PCP)	A Provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse Providers, nurse midwives, or physician assistants) who manages, coordinates, and monitors covered primary care (and sometimes additional services).
Quality Improvement (QI)	Program provides structure and outlines specific activities designed to improve the care, service and health of Molina Medicare Members.
Risk Adjustment	Payment methodology designed to pay appropriate premiums for each Molina Medicare Member. CMS bases its premium payment according to the health status of each Member.
Service Area	The area where a health plan accepts Members. For plans that require participating doctors and hospitals to be used, it is also the area where services are provided. The plan may disenroll Members who move out of the plans service area.
Skilled Nursing Care	A facility with licensed, clinical staff and equipment which provide skilled care and services.
TTY	A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have severe speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don't have a TTY can communicate with a TTY user through a message relay center

Term	Definition
	(MRC). An MRC has TTY operators available to send and interpret TTY messages.
Urgently Needed Services	Immediate care for a sudden illness or injury that is not life threatening. PCPs generally provide urgently needed care if the Member is in a Medicare health plan other than the Original Medicare Plan. If a Member is out of the plan's service area for a short time and cannot wait until they return home, the health plan must pay for urgently needed care.
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/Medicare programs.