COMPLIANCE

Health Insurance Portability and Accountability Act (HIPAA)

Molina Healthcare's Commitment to Patient Privacy

Protecting our members' personal health information is a responsibility that Molina Healthcare takes very seriously. Molina Healthcare complies with all federal and state laws regarding the privacy and security of protected health information (PHI).

Provider/Practitioner Responsibilities

Molina Healthcare expects its contracted providers to respect the privacy of Molina Healthcare members and comply with all applicable laws and regulations regarding the privacy of PHI.

Applicable Laws

Providers must understand all state and federal health care privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States. 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
    - Medicare and Medicaid laws
2. Ohio Medical Privacy Laws and Regulations

HIPAA provides a floor for patient privacy but state laws should be followed, especially if the state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address specific situations.

USES AND DISCLOSURES OF PHI

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 to the TPO of another covered entity.[1] Disclosure of PHI by one covered entity to another covered entity or health care provider for their 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. Payment is a defined term under the HIPAA Privacy Rule that includes, without

[1] See Sections 164.506(c)(2) & (3) of the HIPAA Privacy Rule.

limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of services.[2]

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

- Quality improvement
- Disease management
- Case management and care coordination
- Training programs
- Accreditation, licensing, and credentialing

This allows providers to share PHI with Molina Healthcare for our health care operations activities, such as Healthcare Effectiveness Data and Information Set (HEDIS®) and quality improvement. Please see the table, Categories of Permitted Uses and Disclosures of PHI, at the end of this chapter for an overview of acceptable TPO activities.

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.

Patient Rights

Patients are afforded rights under HIPAA. Molina Healthcare providers must allow patients to exercise any of the rights listed below that apply to the provider's practice:

1. *Notice of Privacy Practices*
Providers that are covered under HIPAA who 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 use and disclosure of PHI. The provider is not required to agree to any such request for restriction.

3. *Requests for Confidential Communications*
Patients may request that a health care provider communicate PHI by alternate means or at alternate 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 both the patient's medical record and billing and other records used to make decisions about the member's care or payment for care.

[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

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 TPO or made prior to April 14, 2003.

HIPAA Security

Providers should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI.

Identity theft is a rapidly growing problem. Patients trust providers to keep their health care information private and confidential. In addition, medical identity theft is an emerging threat in the health care industry. Medical identity theft is when a person's name and other parts of their identity, such as health insurance information, are used without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries in medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina Healthcare.

HIPAA Transactions and Code Sets

Molina Healthcare strongly supports the use of electronic transactions to streamline health care administrative activities. Molina Healthcare providers are encouraged to submit claims and other transactions to Molina Healthcare using electronic formats. Certain electronic transactions are subject to HIPAA 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 Healthcare is committed to complying with all HIPAA Transactions and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at www.MolinaHealthcare.com for additional information.

National Provider Identifier

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. Providers must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for themselves or for any subparts of the provider. The NPI and any subparts must be reported to Molina Healthcare and to any other entity that requires it. Any changes in NPI or subparts must be reported to NPPES within 30 days and should also be reported to Molina Healthcare within 30 days of the change. Providers must use NPI on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Healthcare.

Additional Requirements for Delegated Providers/Practitioners

Providers delegated for claims and utilization management activities are the business associates of Molina Healthcare. Under HIPAA, Molina Healthcare must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated providers must agree to the contractual provisions required under HIPAA's Privacy and Security Rules.

Categories of Permitted Uses & Disclosures of PHI

TREATMENT (T)	PAYMENT (P)	HEALTHCARE OPERATIONS (HCO)	OTHER PERMITTED USES & DISCLOSURES (OP)
Referrals Provision of Care by Providers	Eligibility Verification Enrollment/Disenrollment Claims Processing and Payment Coordination of Benefits Subrogation Third Party Liability Encounter Data Member UM/Claims Correspondence Capitation Payment and Processing Collection of Premiums or reimbursements Drug Rebates Reinsurance claims Utilization Management Pre-authorizations Concurrent Reviews Retrospective Reviews Medical Necessity Reviews	Quality Assessment and Improvement: Member satisfaction surveys; Population based QI studies; HEDIS measures; Development of clinical guidelines; Health Improvement activities; Case and Care Management; Contacting providers and members about treatment alternatives; Disease management; Credentialing and Accreditation Licensing; Provider Credentialing; Accreditation, (e.g., NCQA); Evaluating provider or practitioner performance; Underwriting or contract renewal; Auditing -- conducting or arranging for: Auditing; Compliance; Legal; Fraud and Abuse detection; Medical review Business Planning and Development Cost management; Budgeting; Formulary Development; Mergers and acquisitions, including due diligence Business Management and General Administrative activities Member Services, including complaints and grievances and member materials fulfillment; De-identification of data Records & document management (if the documents contain PHI)	Public Health ▪ Reporting to Immunization ▪ registries ▪ Reporting of disease and ▪ vital events; Reporting of child abuse or neglect; Report adverse events for FDA-regulated products; Victims of Abuse, Neglect or Domestic Violence (except for child abuse) 1. To Regulators (e.g., Ohio Department of Insurance) for Health Care Oversight, including audits, civil and criminal investigations 2. Judicial and Administrative Proceedings: ▪ Court orders; ▪ Subpoenas and discovery ▪ requests (without court order); ▪ Workers' Compensation 3. Disclosures for Law Enforcement ▪ Court ordered warrants and summons; ▪ Grand jury subpoenas; ▪ Identification and Location purposes 4. Information about Decedents ▪ to coroners and medical examiners; ▪ to Funeral directors; ▪ Organ Donation 5. Research, e.g., clinical trials; 6. Special Government Functions; ▪ Military activities; ▪ National security ▪ Protective services for the President

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Fraud, Waste, and Abuse

Introduction

Molina Healthcare of Ohio maintains a comprehensive Fraud, Waste, and Abuse program. The program is held accountable for the special investigative process in accordance with federal and state statutes and regulations. Molina Healthcare of Ohio is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, the Compliance department maintains a comprehensive plan, which addresses how Molina Healthcare of Ohio will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare of Ohio.

Mission Statement

Molina Healthcare of Ohio 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 Healthcare of Ohio has therefore implemented a program to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, 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

On February 8, 2006, the Deficit Reduction Act ("DRA") was signed into law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs. Health care entities like Molina Healthcare of Ohio who receive or pay out at least $5 million in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina Healthcare of Ohio, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protection rights as a whistleblowers.

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority;
- Two times the amount of back pay plus interest;
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare will take steps to monitor Molina Healthcare of Ohio contracted providers to ensure compliance with the law.

DEFINITIONS

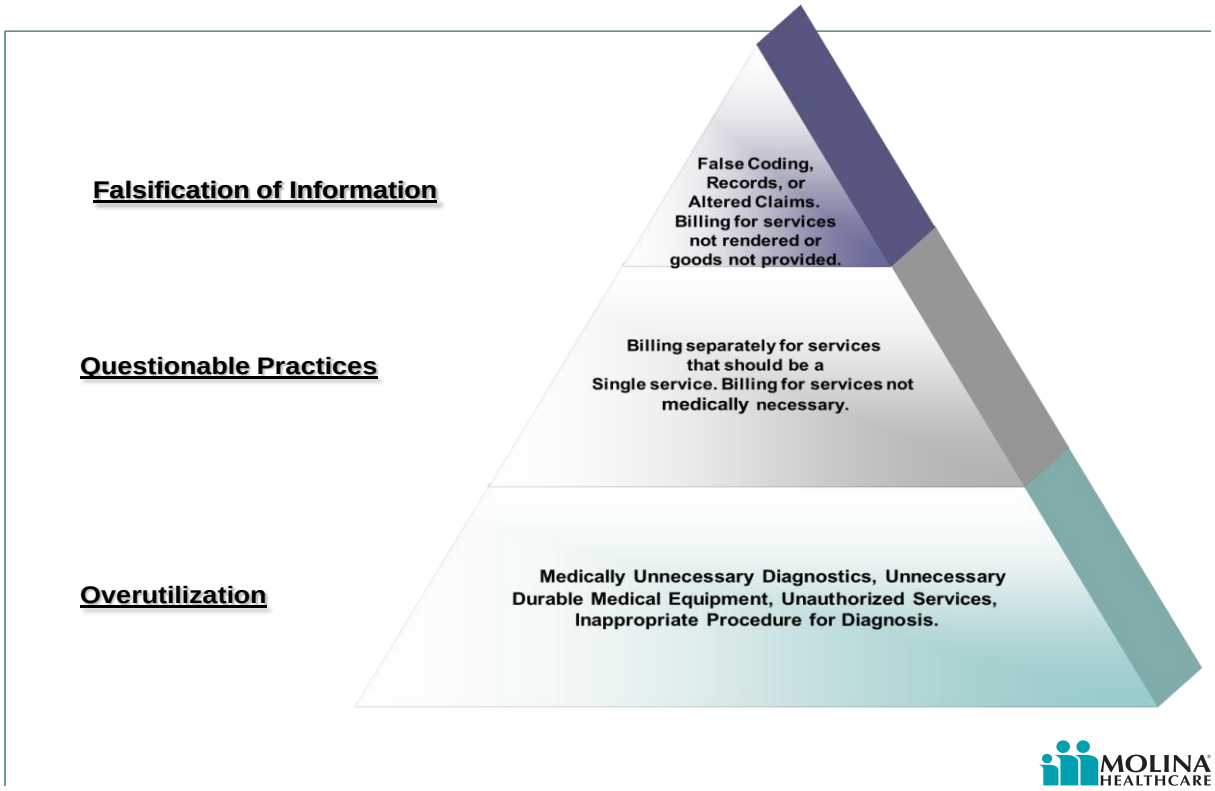
Fraud:
"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)
Waste:
Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.
Abuse:
"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered.
- Providing services to patients that are not medically necessary.
- Balance Billing a Medicaid member for Medicaid covered services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the

recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "up-coding", and billing for services not provided.

- Concealing patients misuse of Molina Healthcare of Ohio identification card.
- Failure to report a patient's forgery/alteration of a prescription.
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients.
- A physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)



Review of Provider

The Credentialing Department is responsible for monitoring practitioners through the various government reports, including:

- Federal and State Medicaid sanction reports.
- Federal and state lists of excluded individuals and entities including the Ohio Office of Inspector General's exclusion list.
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Medicaid 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 Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

Provider/Practitioner Education

When Molina Healthcare of Ohio identifies through an audit or other means a situation with a provider (e.g. coding, billing) that is either inappropriate or deficient, Molina Healthcare of Ohio may determine that a provider/practitioner education visit is appropriate.

The Molina Healthcare of Ohio Provider Services Representative will inform the provider's office that an on-site meeting is required in order to educate the provider on certain issues identified as inappropriate or deficient.

Review of Provider Claims and Claims System

Molina Healthcare 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 preformed as authorized.

Molina Healthcare of Ohio 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.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare 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 24 hours a day, 7 days a week, 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 Healthcare 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 Healthcare AlertLine can be reached toll free at 1-866-606-3889 or you may use the service's website to make a report at any time at **https://molinahealthcare.alertline.com**

You may also report cases of fraud, waste or abuse to Molina Healthcare of Ohio's Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Ohio
Attn: Compliance
3000 Corporate Exchange Drive
Columbus, Ohio 43231
Remember to include the following information when reporting:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to the state at:

If you suspect that a Medicaid recipient has committed fraud or abuse, you would like to report it, please contact the County Department of Job and Family Services in the county in which the consumer resides. The number can be found in the telephone book under "County Government." If you are unable to locate the number, please call the ODJFS General Information Customer Service number at 1-877-852-0010 for assistance.

If you suspect a provider to have committed fraud or abuse of the Medicaid program, or have specific knowledge of corrupt or deceptive practices by a provider, you should contact the Ohio Attorney General's Medicaid Fraud Control Unit at (614) 466-0722, or the Attorney General's Help Center at (800) 282-0515.

DEFICIT REDUCTION ACT (DRA)

The Deficit Reduction Act (DRA) was signed into law on February 8, 2006 and became effective on January 1, 2007. The law aims to cut fraud, waste and abuse from the Medicare and Medicaid programs. Health care entities, like Molina Healthcare, who receive or pay out at least $5 million in Medicaid funds per year, must comply with DRA. These entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protected rights as whistleblowers.

As a Molina Healthcare of Ohio, Inc. provider, you are either a covered entity or contractor/agent. Contractors/agents are required to follow Molina Healthcare's policy and procedures on the DRA, Fraud and Abuse.

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit of their own. 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 furthering a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority
- Two times the amount of back pay plus interest
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions

The Federal False Claims Act and the Medicaid False Claims Act contain some overlapping language related to personal liability. For instance, the Medicaid False Claims Act has the following triggers:

- Presents, or causes to be presented to the state, a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it.
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use.
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or re-certification required by the Medicaid program.
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided.

Affected entities, contractors or agents who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare will take steps to monitor contracted providers to ensure compliance with the law.

For more information on this legislation, or to obtain a copy of Molina Healthcare's policy and procedures on the DRA, Fraud and Abuse please contact your Molina Provider Services Representative at 1-800-642-4168.