2016 PROVIDER MANUAL

Molina Healthcare of Florida, Inc.

Molina Medicare Options Plus

(HMO Special Needs Plan)

Version 2, February 2016

Thank you for your participation in the delivery of quality healthcare services to Molina Healthcare Members. We look forward to working with you.

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

The information contained within this 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 Healthcare.

The Provider Manual is a reference tool that contains eligibility, benefits, contact information and policies/procedures for services that Molina Healthcare Medicare specifically provides and administers on behalf of Molina Healthcare.

Dear Provider:

Welcome to Molina Healthcare of Florida, Inc. Enclosed is your Medicare Provider Manual, written specifically to address the requirements of delivering healthcare services to Molina Healthcare Members.

This Manual is designed to provide you with assistance in all areas of your practice, from making referrals to receiving payment for your services. In some cases, you may have developed internal procedures that meet the standards set out in this Manual. In these instances, you do not need to change your procedures as long as they adhere to the standards outlined in 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 Healthcare website as they occur. All contracted Providers will receive an updated Provider Manual annually, which will be made available at www.MolinaHealthcare.com.

Thank you for your active participation in the delivery of quality healthcare services to Molina Healthcare Members.

Sincerely,

Maritza Borrajero
President
Molina Healthcare of Florida, Inc.

Table of Contents

1. Introduction

Molina Medicare Options Plus (HMO SNP) is the brand name of Molina Healthcare of Florida, Inc.'s Medicare line of business.

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

A. Molina Medicare Options Plus (HMO SNP) Special Needs Plan

Options Plus (HMO SNP) is the name of Molina Healthcare's Special Needs Plan (HMO SNP), which provides Medicare Advantage and Prescription Drug Benefits. The Options Plus 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. Options Plus (HMO SNP) embraces Molina Healthcare's longstanding mission to serve those who are the most in need and traditionally have faced barriers to quality health care.

Please contact the Member & Provider Contact Center (M&PCC) Monday through Sunday from **8:00 a.m. – 8:00 p.m., toll free at (866) 553-9494** with questions regarding this program.

B. 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 Healthcare website as they occur. All contracted Providers will receive an updated Provider Manual annually, which will be made available at www.MolinaHealthcare.com.

This manual contains samples of the forms needed to fulfill your obligations under your Molina Healthcare 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, Inc. (Molina)

Molina Healthcare, headquartered in Long Beach, California, is a multi-state, managed care company focused on providing healthcare services to people who receive benefits through government-sponsored programs. Molina Healthcare is a physician-led, family-founded health plan that believes each person should be treated like family and that each person deserves quality care.

C. David Molina, M.D., founded the company in 1980 as a provider organization with a network of primary care clinics in California. Included in Molina Healthcare's Provider networks are company-owned and operated primary care clinics, independent Providers and medical groups, hospitals and ancillary Providers.

As the need for more effective management and delivery of healthcare services to underserved populations continued to grow, Molina Healthcare became licensed as a Health Maintenance Organization (HMO) in California. Today, Molina Healthcare serves over 3.4 million Members in eleven (11) states and the Commonwealth of Puerto Rico.

In 2010, Molina Healthcare acquired Unisys' Health Information Management Division to form Molina Medical Solutions (MMS). This business unit provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems.

A. Molina Healthcare's Mission, Vision and Core Values

1. **Mission** – To provide quality health care to persons receiving government assistance.

2. **Vision** – We envision a future where everyone receives quality health care.

3. **Core Values:**

Caring:	We care about hose we serve and advocate on their behalf. We assume the best about people and listen so that we can learn.
Enthusiastic:	We enthusiastically address problems and seek creative solutions.
Respectful:	We respect each other and value ethical business practices.
Focused:	We focus on our mission.
Thrifty:	We are careful with scare resources. Little things matter and the nickels add up.
Accountable:	We are personally accountable for actions and collaborate to get results.

Feedback: We strive to improve the organization and achieve meaningful change through feedback and coaching. Feedback is a gift.

One Molina: We are one organization. We are a team.

B. Significant Growth of Molina

Since 2001, Molina Healthcare, a publicly traded company (NYSE: MOH), has achieved significant Member growth through internal initiatives and acquisitions of other health plans. This strong financial and operational performance is uniquely attributable to the recognition and understanding that Members have distinct social and medical needs, and are characterized by their cultural, ethnic and linguistic diversity.

Since the company's inception thirty (30) years ago, the focus has been to work with government agencies to serve low-income and special needs populations. Success has resulted from:

- Expertise in working with Federal and State government agencies;
- Extensive experience in meeting the needs of Members;
- Owning and operating primary care clinics;
- Cultural and linguistic expertise; and
- A focus on operational and administrative efficiency.

C. The Benefit of Experience

Beginning with primary care clinics in California, the company grew in the neighborhoods where Members live and work. This early experience impressed upon management the critical importance of community-based patient education and greater access to the entire continuum of care, particularly at the times when it can do the greatest good.

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

D. Administrative Efficiency

Molina Healthcare operates its business on a centralized platform that standardizes various functions and practices across all of its health plans in order to increase administrative efficiency. Each state licensed subsidiary contracts with Molina Healthcare, Inc. (MHI) for specific centralized management, marketing, and administrative services.

E. Quality

Molina Healthcare is committed to quality and has made accreditation a strategic goal for each of Molina Healthcare's health plans. Year after year, Molina Healthcare 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.

F. Flexible Care Delivery Systems

Molina Healthcare has constructed its systems for healthcare delivery to be readily adaptable to different markets and changing conditions. Healthcare services are arranged through contracts with Providers that include Molina Healthcare-owned clinics, 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 (DRGs).

G. Cultural and Linguistic Expertise

National census data shows that the United States' population is becoming increasingly diverse. Molina Healthcare has a thirty (30)-year history of developing targeted healthcare 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 that the literacy level is appropriate for our target audience.

H. Member Marketing and Outreach

Member marketing creates an awareness of Molina Healthcare as an option for Medicare-eligible beneficiaries including those who are full dual eligible beneficiaries. Member marketing relies heavily on community outreach efforts primarily through community agencies serving the targeted population. Sales agents, brochures, billboards, physician partners, public relations and other methods are also used in accordance with the Centers for Medicare & Medicaid Services (CMS) marketing guidelines.

3. Contact Information for Providers - Molina Healthcare

Molina Healthcare of Florida, Inc.
8300 NW 33rd Street, Suite 400
Doral, FL 33122

24 HOUR NURSE ADVICE LINE FOR MOLINA HEALTHCARE MEDICARE MEMBERS		
Services available in English and in Spanish.	English Telephone	(888) 275-8750
	Spanish Telephone	(866) 648-3537
	Hearing Impaired (TTY/TDD)	(866) 735-2929
CLAIMS AND CLAIMS APPEALS		
Mailing Address: Molina Options Plus Claims PO Box 22811 Long Beach, CA 90801 Physical Address for overnight packages: Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802	Telephone	(866) 553-9494
COMPLIANCE/ANTI-FRAUD HOTLINE		
Confidential Compliance Official Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802	Telephone	(866) 606-3889
	Email	https://molinahealthcare.alertline.com
CREDENTIALING		
Molina Healthcare of Florida, Inc. Credentialing Department 200 Oceangate, Suite 100 Long Beach CA 90802	Telephone	(866) 422-4585
	Fax	(866) 422-6445
MOLINA HEALTHCARE INSIDE SALES AND PROSPECTIVE MEMBER ADVISORS		
Molina Healthcare Inside Sales	Telephone	(866) 403-8293
	Hearing Impaired (TTY/TDD)	(800) 346-4128

QUALITY IMPROVEMENT		
Molina Healthcare of Florida, Inc. Quality Improvement Department 8300 NW 33rd Street, Suite 400 Doral, FL 33122	Telephone	(866) 422-4585
	Fax	(866) 422-6445
UTILIZATION MANAGEMENT, REFERRALS & AUTHORIZATION		
Molina Healthcare of Florida, Inc. Utilization Management 8300 NW 33rd Street, Suite 400 Doral, FL 33122	Telephone	(866) 472-4585
	Fax	(866) 440-9791
HEARING AND DENTAL		
Avesis Third Party Administrators 10324 S Dolfield Road Owings Mill, MD 21117	Telephone	(800) 327-4462
VISION		
March Vision Care 6701 Center Drive W, Suite 790 Los Angeles, CA 90045	Telephone	(888) 493-4070
TRANSPORTATION		
Secure Transportation 13111 Meyer Road Whittier, CA 90605	Telephone	(800) 856-9994
	Hearing Impaired (TTY/TDD)	(844) 292-2690

4. Eligibility and Enrollment in Molina Healthcare Medicare Plans

A. Members who wish to enroll in Molina Healthcare Medicare Options Plus (HMO SNP), a Medicare Advantage Prescription Drug Special Needs Plan, must meet the following eligibility criteria:

- Be entitled to Medicare Part A and enrolled in Medicare Part B;
- Not be medically determined to have ESRD prior to completing the enrollment form (unless individual is an existing Molina Healthcare Medicaid Member);
- Permanently reside in the Molina Healthcare Medicare service area, which includes the following counties in **2016: Miami-Dade, Broward, Palm Beach, Hillsborough, Pasco, Pinellas, and Polk.** Member or Member's legal representative completes an enrollment election form completely and accurately;
- Is fully informed and agrees to abide by the rules of Molina Healthcare Medicare;
- The Member makes a valid enrollment request that is received by the plan during an election period; and
- Is entitled to Full Medicaid benefits as defined by the State of Florida.

Further,

- Molina Healthcare does not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in MMCM Chapter 2.

B. Enrollment/Disenrollment Information

All Members of **Molina Healthcare Medicare Options Plus (HMO SNP)** 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 **throughout the year.**

C. Prospective Members Toll-Free Telephone Numbers

Existing Members may call our Member & Provider Contact Center (M&PCC) Monday-Sunday 8:00 a.m. to 8:00 p.m. local time. TTY/TDD users call 711.

- **FL – (866) 403-8293**

D. Effective Date of Coverage

The MA organization must determine the effective date of enrollment for all enrollment requests. The effective date of coverage is determine of when the complete enrollment is signed, received, following the members enrollment election period.

E. Disenrollment

Staff of Molina Healthcare may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare Member to disenroll except when the Member has:

- Permanently moved outside Molina Healthcare's service area;

- Lost Medicaid eligibility (for dual eligible enrolled in Molina Healthcare MA Special Needs Plan
- Lost Medicare Part A or B.

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

- Out-of-area notification will be received from CMS on the Daily Transaction Reply Report (DTRR);
- The Member may call to advise Molina Healthcare that they have permanently relocated; 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 Healthcare does not offer a visitor/traveler program to Members).

F. Requested Disenrollment

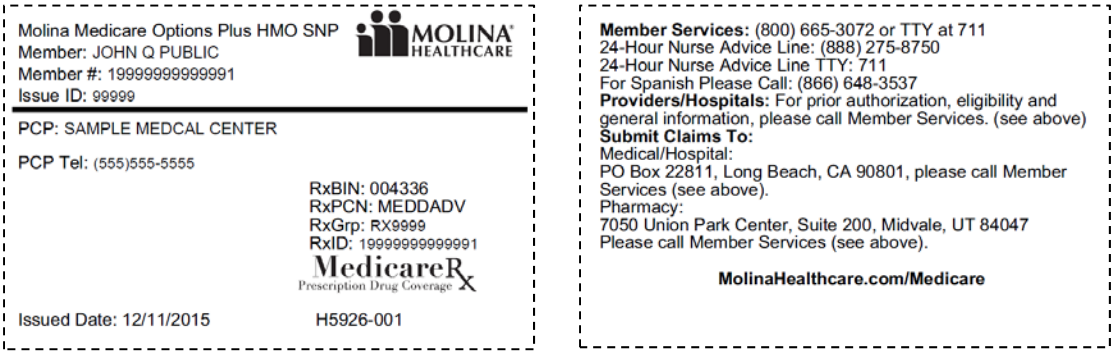
Molina Healthcare will process disenrollment of Members from the health plan only as allowed by CMS regulations. Molina Healthcare will request that a Member be disenrolled under the following circumstances:

- Member requests disenrollment; (during a valid election period);
- Member enrolls in another plan (during a valid enrollment period);
- Member leaves the service area and directly notifies Molina Healthcare of the permanent change of residence;
- Member loses entitlement to Medicare Part A or Part B benefits;
- Member loses Medicaid eligibility;
- Molina Healthcare loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina Healthcare 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 Healthcare discontinues offering services in specific service areas where the Member resides.

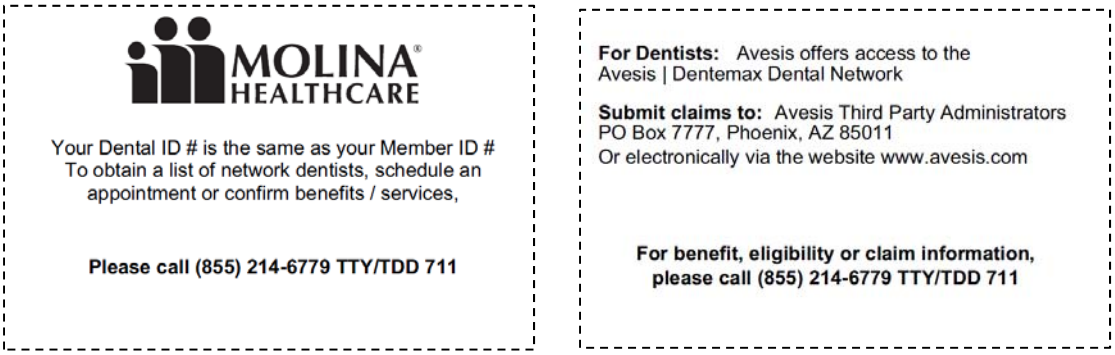
In all circumstances except death, Molina Healthcare will provide a written notice to the Member with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS.

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

G. Member Identification Card Example – Medical Services



H. Member Identification Card Example – Dental Services



I. Verifying Eligibility

To ensure payment, Molina Healthcare 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 Provider to verify the eligibility of the cardholder.

Dual Eligible and Cost Share

Molina Healthcare allows Members to enroll who have all levels of Medicaid assistance. These Members may or may not be entitled to cost-share assistance, and may or may not have Medicaid benefits. Providers can find cost-share information on an individual Molina Healthcare SNP Member through the Molina Healthcare Provider Portal at www.MolinaHealthcare.com. Below is a cost-share chart to reference:

Cost-Share Grid

Applies to all Molina Healthcare Medicare/Healthy Advantage states except CA and TX
CA and TX are $0 cost-share plans

Type	Medicare Parts A and B Cost-Share	Preventive
QMB	0%	0%
QMB+	0%	0%

Cost-Share Grid *Applies to all Molina Healthcare Medicare/Healthy Advantage states except CA and TX* *CA and TX are $0 cost-share plans*		
Type	**Medicare Parts A and B Cost-Share**	**Preventive**
SLMB	0% When service is covered by both Medicare and Medicaid Otherwise 20% *(Medicare Part A and B deductibles apply if 20%)*	0%
SLMB+	0%	0%
QI	20% *(Medicare Part A and B deductibles apply)*	0%
QDWI	20% *(Medicare Part A and B deductibles apply)*	0%
FBDE	0% When service is covered by both Medicare and Medicaid Otherwise 20% *(Medicare Part A and B deductibles apply if 20%)*	0%
00	20% *(Medicare Part A and B deductibles apply)*	0%
09	20% *(Medicare Part A and B deductibles apply)*	0%
99	Unknown; assess 0% at time of service, check back 2nd week of following month	0%

5. Benefit Overview

A. Questions about Molina Healthcare Medicare Benefits

If there are questions as to whether a service is covered or requires prior authorization, please contact **Molina Healthcare's Medicare Member & Provider Contact Center (M&PCC) Monday through Sunday 8:00 a.m. to 8:00 p.m. toll free at (866) 553-9494, or 711 for persons with hearing impairments (TTY/TDD).**

B. Links to Summaries of Benefits

The following web link provides the Summary of Benefits for the 2016 Molina Healthcare Medicare Options Plus Special Needs Plan (HMO SNP) plan in Florida:
www.MolinaHealthcare.com

C. Links to Evidence of Coverage

Detailed information about benefits and services can be found in the 2016 Evidence of Coverage booklets sent to each Molina Healthcare Medicare Member.

The following web link provides the Evidence of Coverage for the 2016 Molina Healthcare Medicare Options Plus Special Needs Plan (HMO SNP) plan in Florida:
www.MolinaHealthcare.com

Please note for **2016**: The Medicare-covered initial preventive and physical examination (IPPE) and the annual wellness visit are covered at zero cost sharing. Our plans cover Medicare-covered preventive services at no cost to the Member.

6. Quality Improvement

Molina Healthcare of Florida, Inc. maintains a Quality Improvement (QI) Department to work with Members and Providers in administering the Molina Healthcare Quality Improvement Program. You can contact the Molina Healthcare QI Department **toll free at (866) 422-4585, or fax (866) 422-6445.**

The address for mail requests is:

Molina Healthcare of Florida, Inc.
Quality Improvement Department
8300 NW 33rd Street, Suite 400
Doral, FL 33122

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

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

- Have a Quality Improvement Program in place;
- Comply with and participate in Molina Healthcare's Quality Improvement Program including reporting of Access and Availability and provision of medical records as part of the quality of care, quality improvement and HEDIS® reporting activities; and
- Allow access to Molina Healthcare QI personnel for review of site and medical record keeping and documentation practices.

A. Patient Safety Program

Molina Healthcare's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Healthcare Members in collaboration with their Primary Care Providers. Molina Healthcare 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 Healthcare monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) is 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 Healthcare has an established and systematic process to identify, investigate, review and report any Quality of Care, Adverse Event/Never Event, and/or service issues affecting Member care. Molina Healthcare 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 Healthcare is not required to pay for inpatient care related to "never events".

C. Medical Records

Molina Healthcare 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. Molina Healthcare conducts a medical record review of Primary Care Providers (PCPs) every three (3) years that includes the following components:

- Medical record confidentiality and release of medical records including mental/behavioral health care records;
- Medical record content and documentation standards, including preventive health care;
- Storage maintenance and disposal; and
- Process for archiving medical records and implementing improvement activities.

Providers must demonstrate compliance with Molina Healthcare's medical record documentation guidelines. Medical records are assessed based on the following standards:

1. Content

- Patient name or ID is on all pages;
- Current biographical data is maintained in the medical record or database;
- All entries contain author identification;
- All entries are dated;
- Medication allergies and adverse reactions are prominently displayed. Absence of allergies is noted in easily recognizable location;
- Chronic conditions are listed or noted in easily recognizable location;
- Past medical history for patients seen more than three (3) times is noted;
- There is appropriate notation concerning use of substances, and for patients seen three (3) or more times, there is evidence of substance abuse query;

- The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints;
- Consistent charting of treatment care plan;
- Working diagnoses are consistent with findings;
- Treatment plans are consistent with diagnoses;
- Encounter notation includes follow up care, call, or return instructions;
- Preventive health measures (e.g., immunizations, mammograms, etc.) are noted;
- A system is in place to document telephone contacts;
- Lab and other studies are ordered as appropriate;
- Lab and other studies are initialed by ordering Provider upon review
- Lab results and other studies are filed in chart;
- If patient was referred for consult, therapy, or ancillary service, a report or notation of result is noted at subsequent visit, or filed in medical record;
- If the Provider admitted a patient to the hospital in the past twelve (12) months, the discharge summary must be filed in the medical record

2. **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; and
- Chart sections are easily recognized for retrieval of information.

3. **Retrieval**

- The medical record is available to Provider at each Encounter;
- The medical record is available to Molina Healthcare for purposes of quality improvement;
- Medical record retention process is consistent with State and Federal requirements; and
- An established and functional data recovery procedure in the event of data loss.

4. **Confidentiality**

- Medical Records are protected from unauthorized access;
- Access to computerized confidential information is restricted; and
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.

Additional information on medical records is available from your local Molina Healthcare Quality Improvement Department **toll free at (866) 422-4585.** See also Section 7 regarding the Health Insurance Portability and Accountability Act (HIPAA).

D. Access to Care

Molina Healthcare is committed to timely access to care for all Members in a safe and healthy environment. Providers are required to conform to the Access to Care appointment standards listed below to ensure that healthcare services are provided in a timely manner. The standards are

based on ninety-five percent (95%) availability for Emergency Services and eighty percent (80%) 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 Healthcare Members in the timeframes noted:

Primary Care Provider (PCP)	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Emergency Care	Triage and treat immediately
Acute/Urgent Care	Within twenty-four (24) hours of the request.
Preventive Care, Appointment	Within thirty (30) calendar days of the request
Routine Primary Care	Within seven (7) calendar 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.
Specialty Care Provider (SCP)	
Types of Care for Appointment	**Appointment Wait Time (Appointment Standards)**
Routine Care	Within ten (10) calendar days of the request

Additional information on appointment access standards is available from your local Molina Healthcare QI Department **toll free at (866) 472-4585.**

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 Healthcare 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 Healthcare Member & Provider Contact Center (M&PCC) **toll free at (866) 553-9494,** or **711 for TTY/TDD**;

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, and 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 Healthcare must receive thirty (30) days advance written notice from the Provider.

5. **Monitoring Access for Compliance with Standards -** Molina Healthcare monitors compliance with the established access standards above. At least annually, Molina Healthcare conducts an access audit of randomly selected contracted Provider offices to determine if appointment access standards are met. One or all of the following appointment scenarios may be addressed: routine care; acute care; preventive care; and after-hours information. Results of the audit are distributed to the Providers after its completion. A corrective action plan may be required if standards are not met.

   In addition, Molina Healthcare's Member & Provider Contact Center (M&PCC) reviews Member inquiry logs and grievances related to delays in access to care. These are

reported quarterly to committees. Delays in access that may create a potential quality issue are sent to the QI Department for review.

Additional information on access to care is available under the Resources tab available from your local Molina Healthcare Quality Improvement Department **toll free at (866) 472-4585.**

E. Site and Medical Record Keeping Practice Reviews

Molina Healthcare has a process to ensure that the offices of all Providers meet its office-site and medical record keeping practices standards. Molina Healthcare continually monitors Member complaints 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 Healthcare 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 outlined below 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

Physical Accessibility

Molina Healthcare 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 Healthcare 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 Healthcare 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 Healthcare assesses one (1) medical/treatment record for orderliness of record and documentation practices. To ensure Member confidentiality, Molina Healthcare reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

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 below. 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.

Facility:

- 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.

Safety:

- 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.

Administration & Confidentiality:

- 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 injectibles and emergency medication are checked monthly for outdates.

- Drug refrigerator temperatures are documented daily.

Monitoring Medical Record keeping practice Guidelines and Compliance Standards

Provider medical record keeping practices must demonstrate an overall eighty percent (80%) compliance with the Medical Record Keeping Practice Guidelines listed below. 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.

- Each patient has a separate medical record. File markers are legible. Records are stored away from patient areas and preferably locked. Record is available at each patient visit. Archived records are available within twenty-four (24)-hours.
- Pages are securely attached in the medical record. Computer users have individual passwords.
- Medical records are organized by dividers or color-coding when the thickness of the record dictates.
- A chronic problem list is included in the record for all adults and children.
- Allergies (and the lack of allergies) are prominently displayed at the front of the record.
- A complete health history questionnaire or H&P is part of the record.
- Health Maintenance forms includes dates of preventive services.
- A medication sheet is included for chronic medications.
- Advance Directives discussions are documented for those eighteen (18) years and older.
- Record keeping is monitored for Quality Improvement and HIPAA compliance.
- Within thirty (30) calendar days of the review, a copy of the site review report, the medical record keeping practices report and a letter will be sent to the medical group notifying them of their results.

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 Healthcare 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 corrective action plan (CAP) to Molina Healthcare within thirty (30) calendar days of

notification by Molina Healthcare. 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 Healthcare Fair Hearing Plan policy.

F. Advance Directives (Patient Self-Determination Act)

Providers must inform patients of their right to make health care decisions and execute advance directives. It is important that Members are informed about advance directives. During routine Medical Record review, Molina Healthcare auditors will look for documented evidence of discussion between the Provider and the Member. Molina Healthcare will notify the Provider of an individual Member's advance directives identified through care management, Care Coordination or Case Management. Providers are instructed to document the presence of an advance directive in a prominent location of the Medical Record. Auditors will also look for copies of the form. Advance directives forms are state specific to meet state regulations. For copies of forms applicable to your state, please go to the Caring Connections website at http://www.caringinfo.org/stateaddownload for forms available to download. Additionally, the Molina Healthcare website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

Advance directives are a written choice made by a patient for health care treatment. There are two (2) kinds of directives – Durable Power of Attorney for Health Care and Directive to Physicians. Written advance directives tell the PCP and other medical Providers how Members choose to receive medical care in the event that they are unable to make end-of life decisions.

Each Molina Healthcare Provider must honor advance directives to the fullest extent permitted under law. PCPs must discuss advance directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance. Molina Healthcare's network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service whenever possible. In no event may any Provider refuse to treat or otherwise discriminate against a Member because the Member has completed an advance directive. Medicare law gives Members the right to file a complaint with Molina Healthcare – Healthcare or the state survey and certification agency if the Member is dissatisfied with Molina Healthcare's handling of advance directives and/or if a Provider fails to comply with advance directive instructions.

Durable Power of Attorney for Health Care: This advance directive names another person to make medical decisions on behalf of the Member when they cannot make the choices for themselves. It can include plans about the care a Member wants or does not want and includes information concerning artificial life-support machines and organ donations. This form must be signed, dated and witnessed by a notary public to be valid.

Directive to Physicians (Living Will): This advance directive usually states that the Member wants to die naturally without life-prolonging care and can also include information about any desired medical care. The form would be used if the Member could not speak and death would occur soon. This directive must be signed, dated and witnessed by two (2) people who know the Member well but are not relatives, possible heirs, or healthcare Providers.

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.

G. Quality Improvement Activities and Programs

Molina Healthcare 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.

1. **Disease Management Programs -** Molina Healthcare has established disease management programs to measure and improve health status and quality of life. The Disease Management Programs involve a collaborative team approach comprised of health education, clinical case management and Provider education. The team works closely with contracted Providers in the identification, assessment and implementation of appropriate interventions. Currently these programs are made available to all eligible Molina Healthcare Members based on inclusion criteria, and to all network Providers.
   - Heart Healthy Living Program
     (Addresses High Blood Pressure, Coronary Artery Disease and/or Congestive Heart Failure)
   - Healthy Living with Diabetes℠ Program
   - Healthy Living with Chronic Obstructive Pulmonary Disease
   - Breathe with Ease℠ Asthma Program
   - Medication Therapy Management
   - Smoking Cessation
   - Weight Management

   a. **Program Eligibility Criteria and Referral Source -** Disease Management Programs are designed for active Molina Healthcare Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the Member opts out. Each identified Member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified Members will

receive regular educational newsletters. The program model provides an "opt-out" option for Members who contact Molina Healthcare Member & Provider Contact Center (M&PCC) and request to be removed from the program.

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

- Pharmacy claims data for all classifications of medications;
- Encounter data or paid claim with a relevant CPT-4 or CMS-approved diagnostic and procedure code;
- Member & Provider Contact Center (M&PCC) welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Provider referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through Member newsletter, the Molina Healthcare Nurse Advice Line or other Member communication.

b. **Provider Participation -** Contracted Providers are automatically notified whenever their patients are enrolled in a disease management program. Provider resources and services may include:

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

Additional information on disease management programs is available from your local Molina Healthcare QI Department **toll free at (866) 472-4585.**

2. **Clinical Practice Guidelines -** Molina Healthcare 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 Healthcare Clinical Practice Guidelines include but are not limited to the following:

- Coronary Artery Disease and/or Congestive Heart Failure
- Hypertension
- Diabetes
- Chronic Obstructive Pulmonary Disease

- Asthma
- Cholesterol Management
- Depression

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 Services Departments. The guidelines are disseminated through Provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina Healthcare Website. Individual providers or Members may request copies from your local Molina Healthcare QI Department **toll free at (866) 472-4585**.

3. **Preventive Health Guidelines -** Molina Healthcare 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:
   - Mammography Screening;
   - Prostate cancer screening;
   - Cholesterol screening;
   - Colorectal screening; or
   - Influenza, pneumococcal and hepatitis vaccines.

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

4. **Cultural and Linguistic Services -** Molina Healthcare serves a diverse population of Members with specific cultural needs and preferences. Providers are responsible to ensure that interpreter services are made available at no cost for Members with sensory impairment and/or who are Limited English Proficient (LEP). The following cultural and linguistic services are offered by Molina Healthcare to assist both Members and Providers.

   a. **Twenty-Four (24) Hour Access to Interpreters -** Providers may request interpreters for Members whose primary language is other than English by calling **Molina Healthcare's Member & Provider Contact Center (M&PCC) toll free at (866) 553-9494.** If **Member & Provider Contact Center (M&PCC)** Representatives are unable to provide the interpretation services directly, the Member and Provider will be immediately connected to a telephonic interpreter service.

      If a Member is not willing to use an interpreter and requests a family member as an interpreter after being notified of his or her right to have a qualified interpreter at no cost, document their request in their medical record. Molina Healthcare is

available to assist you in notifying Members of their right to an interpreter. All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done via interpreter services. Providers should document who provided the interpretation service. That information could be the name of their internal staff or someone from a commercial vendor such as Cyracom. Information should include the interpreter's name, operator code number and vendor.

b. Additional information on cultural and linguistic services, such as cultural competency trainings and/or consultations, is available at www.MolinaHealthcare.com from your local Provider Services Representatives and from the Molina Healthcare Member & Provider Contact Center (M&PCC).

c. **Members with Hearing Impairment –** Molina Healthcare provides a TTY connection, which may be reached by dialing **711.** This connection provides access to Member & Provider Contact Center (M&PCC), Quality Improvement, Healthcare Services and all other health plan functions.

The Molina Healthcare Nurse Advice Line may be reached via a TTY connection by dialing **711.**

H. Measurement of Clinical and Service Quality

Molina Healthcare 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 Healthcare's most recent results can be obtained from your local Molina Healthcare QI Department **toll free at (866) 472-4585**.

1. **Healthcare Effectiveness Data and Information Set (HEDIS®) -** Molina Healthcare 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, glaucoma screening, medication use and cardiovascular disease.

   HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina Healthcare'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.

2. **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) -** CAHPS® is the tool used by Molina Healthcare to summarize Member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Promotion and Education, Coordination of Care and Customer Service. The CAHPS® survey is administered annually in the spring to randomly selected Members by a NCQA© certified vendor.

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

3. **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.

4. **Provider Satisfaction Survey -** Recognizing that HEDIS® and CAHPS® both focus on Member experience with healthcare Providers and health plans, Molina Healthcare conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina Healthcare, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Healthcare Provider Network. The survey results have helped establish improvement activities relating to Molina Healthcare'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.

5. **Effectiveness of Quality Improvement Initiatives -** Molina Healthcare 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.

Contracted Providers and Facilities must allow Molina Healthcare 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.

I. Medicare Quality Partner Program

Molina Healthcare of Florida, Inc.'s Medicare Quality Partner Program is a bonus payment program that recognizes Providers contracted with Molina Healthcare of Florida, Inc. who have consistently demonstrated sound clinical care practice(s), accurate evaluation and recording of chronic conditions, and quality-focused provision or arrangement of Covered Services on behalf of Molina Healthcare of Florida, Inc.'s Medicare Members.

Additional information on the Medicare Quality Partner Program is located on the Molina Healthcare Medicare Provider Web Portal at www.MolinaHealthcare.com or from your local Provider Services Representatives.

J. Medicare Star Ratings – The Affordable Care Act

With the passage of the Affordable Care Act, the healthcare industry will be subject to greater scrutiny wherever taxpayer dollars are involved. One method of oversight is Medicare "Star Ratings." Star ratings are not new, but in the current regulatory climate, value-based payment will be receiving more focus.

Star Ratings are a system of measurements CMS uses to determine how well physicians and health plans are providing care to Medicare Members. This system is based on nationally-recognized quality goals such as "The Triple Aim" and the Institute of Medicine's "Six Aims," which focus on improving the health and care of your patients, safe and effective care, as well as making care affordable. These aims are realized through specific measures.

Preventive Health:
- Annual wellness/physical exams.
- Glaucoma
- Mammography
- Osteoporosis
- Influenza and Pneumonia Immunizations

Chronic Care Management:
- Diabetes management screenings.
- Cardiovascular and hypertension management screenings.
- Medication adherence for chronic conditions.
- Rheumatoid arthritis management.

Member Satisfaction Survey Questions:
- "…rate your satisfaction with your personal doctor"

- "…rate your satisfaction with getting needed appointments"

A HEDIS® CPT/CMS approved diagnostic and procedural code sheet is available at www.MolinaHealthcare.com

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 Healthcare 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/CMS approved diagnostic and procedural 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. HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Molina Healthcare takes very seriously. Molina Healthcare is committed to complying with all federal and state Laws regarding the privacy and security of Members' protected health information (PHI).

Provider Responsibilities

Molina Healthcare expects that its contracted Provider will respect the privacy of Molina Healthcare 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.

Applicable Laws

Providers must understand all state and federal healthcare 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 healthcare Providers are subject to various Laws and regulations pertaining to privacy of health information, which may include, but are not limited to, the following:

1. Federal Laws and Regulations
   - HIPAA
   - The Health Information Technology for Economic and Clinical Health Act (HITECH)
   - Medicare and Medicaid Laws
   - The Affordable Care Act

2. Applicable State Laws and Regulations

Providers should be aware that HIPAA provides a floor for patient privacy but that state Laws should be followed in certain situations, especially if the state Law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and healthcare 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 healthcare 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 healthcare Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2]."

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
   - Quality improvement;
   - Disease management;
   - Case management and care coordination;
   - Training Programs;
   - Accreditation, licensing, and credentialing

Importantly, this allows Providers to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS and quality improvement.

Inadvertent Disclosures of PHI

Molina Healthcare may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Healthcare Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Healthcare Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI, unless otherwise permitted by law.

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.

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

1. **Notice of Privacy Practices**

[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

Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for Restrictions on Uses and Disclosures of PHI**

Patients may request that a healthcare Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**

Patients may request that a healthcare Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for Patient Access to PHI**

Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to Amend PHI**

Patients have a right to request that the Provider amend information in their designated record set.

6. **Request Accounting of PHI Disclosures**

Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

HIPAA Security

Providers should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Healthcare 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 healthcare industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity – such as health insurance information—without the person's knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into

existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina Healthcare.

HIPAA Transactions and Code Sets

Molina Healthcare strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare Providers are encouraged to submit Claims and other transactions to Molina Healthcare 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 Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina Healthcare you should visit our website at www.MolinaHealthcare.com to view additional information. Providers can navigate to this informative page starting from Molina's website:

(1) Select the area titled "For Health Care Professionals"
(2) From the top of the web page, click the tab titled "HIPAA"
(3) Click on the tab titled "HIPAA Transaction Readiness."

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.

About ICD-10

ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System) consists of two (2) parts:

1. ICD-10-CM for diagnosis coding
2. ICD-10-PCS for inpatient procedure coding

ICD-10-CM is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses three (3) to seven (7) digits instead of the three (3) to five (5) digits used with ICD-9-CM, but the format of the code sets is similar.

ICD-10-PCS is for use in U.S. inpatient hospital settings only. ICD-10¬ PCS uses seven (7) alphanumeric digits instead of the three (3) or four (4) numeric digits used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

The transition to ICD-10 is occurring because ICD-9 produces limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is thirty (30) years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

National Provider Identifier

Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina Healthcare 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 Healthcare 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 (both electronic and paper formats) submitted to Molina Healthcare.

Additional Requirements for Delegated Providers

Providers that are 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 various contractual provisions required under HIPAA's Privacy and Security Rules.

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 of Florida

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

3. Specific description of protected health information that may be used/disclosed (*for example, "All of my claims paid by Molina from May 1, 2009 to April 30, 2010"*):

All of my health information including, but not limited to, my medical records, health care claims, authorizations, medications and provider information.

4. The protected health information will be used/disclosed for the following purpose(s) (*for example, "For my legal representation in a lawsuit"*):

To help me with my health care, payment for health care or coordination of my health care.

5. 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.

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

7. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that Molina Healthcare has taken any action in reliance on this authorization.

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

9. This authorization expires on the following date or event* _____
**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.

8. Utilization Management

Molina Healthcare maintains a Utilization Management (UM) Department to work with Members and providers in administering the Molina Healthcare Utilization Management Program. You can contact the Molina Healthcare UM Department for **toll free at (866) 472-4585.**

The address for mail requests is:

Molina Healthcare of Florida, Inc.
8300 NW 33rd Street, Suite 400
Doral, FL 33122

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

Molina Healthcare's Utilization Management (UM) Department is designed to provide comprehensive healthcare 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 Healthcare works in partnership with Members and Providers to promote a seamless delivery of healthcare services. Molina Healthcare'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 Healthcare maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina Healthcare medical management program also ensures that Molina Healthcare only reimburses for services identified as a covered benefit and medically necessary. Elements of the Molina Healthcare 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 Healthcare's UM Policies. Their programs, policies and supporting documentation are reviewed by Molina Healthcare at least annually.

A. Utilization Management Goals

The goals of the UM Program at Molina Healthcare are to:

- Identify medical necessity and appropriateness to ensure efficiency of the healthcare services provided;

- Continually monitor, evaluate and optimize the use of healthcare resources;
- Monitor utilization practice patterns of participating Providers, hospitals and ancillary Providers to identify over and under service utilization;
- Identify and assess the need for Care 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;
- Ensure timely responses to Member appeals and grievances; and
- Continually seek to improve Member and Provider satisfaction with health care and with Molina Healthcare Medicare utilization processes.
- Coordinate services between the Members Medicare and Medicaid benefits when applicable.
- Process authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

B. Medical Necessity Review

In conjunction with regulatory guidance from the Centers for Medicare and Medicaid Services (CMS) and industry standards, Molina Healthcare only reimburses services provided to its Members that are medically necessary. Molina Healthcare may conduct a medical necessity review of all requests for authorization and claims, within the specified time frame governed by Federal law, CMS regulations and Molina Healthcare's policies. This review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively, as long as the review complies with Federal regulations and the Molina Healthcare Hospital or Provider Services Agreement.

C. Clinical Information

Molina Healthcare 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 Healthcare 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 Healthcare Hospital or Provider Services Agreement.

D. Prior Authorization

Molina Healthcare requires authorization for selected medical procedures, pharmaceuticals, medical equipment and services. The list of items requiring prior authorization is subject to change and so is not published here. A copy of the most recent prior authorization requirements can be found at the Molina Healthcare's website – www.MolinaHealthcare.com – Provider page – or a written copy can be obtained by contacting the UM Department at the telephone numbers noted in the introduction to the Utilization Management chapter of this Provider Manual.

Requests for prior authorizations to the UM Department may be sent by telephone, fax, mail based on the urgency of the requested service, or via the Provider Web Portal. Contact telephone numbers, fax numbers and addresses are noted in the introduction of this section.

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

a. Member demographic information (Name, DOB, ID #, etc.).
b. Clinical indications necessitating service or referral.
c. Provider information (Referring provider and referred to specialist).
d. Pertinent medical history (include treatment, diagnostic tests, examination data).
e. Requested service/procedure (including specific CPT/HCPCS Codes).
f. Location where the service will be performed.
g. Member diagnosis (CMS-approved diagnostic and procedure code and descriptions).
h. Requested length of stay (for inpatient requests).
i. Indicate if request is for expedited or standard processing.

Molina Healthcare will process prior authorization requests both standard and expedited within the timeframes specified by applicable Federal regulations.

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. Verbal and fax notification of denials are given within seventy-two (72) hours for expedited Medicare requests and fourteen (14) days for standard Medicare requests The written letter is mailed at the time the denial is issued.

Molina Healthcare 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 Healthcare Medical Director believes that a discussion with the requesting physician would assist Molina Healthcare in reaching a favorable determination (within the obligatory timeframes stated above for a standard or expedited request).

Medicare says that if Molina Healthcare, 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 Healthcare 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 Healthcare'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 Healthcare to request a Peer-to-Peer review, we will advise that you must follow the rules for requesting a Medicare appeal (reference Section 14 for Complaints, Grievance and Appeals process).

E. Affirmative Statement about Incentives

Molina Healthcare 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 Healthcare and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Furthermore, Molina Healthcare 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 Healthcare or the delegated group. Molina Healthcare 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 Healthcare 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.

F. Open Communication about Treatment

Molina Healthcare 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 Healthcare 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 Healthcare 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.

G. Utilization Management Functions Performed Exclusively by Molina Healthcare

The following UM functions are conducted by Molina Healthcare (or by an entity acting on behalf of Molina Healthcare) and are **never delegated**:

1. **Transplant Case Management -** Molina Healthcare does not delegate management of transplant cases to the medical group. Providers are required to notify Molina Healthcare's UM Department when the need for a transplant evaluation has been identified. Contracted Providers must obtain prior authorization from Molina Healthcare Medicare for transplant evaluations and surgery. Upon notification, Molina Healthcare conducts medical necessity review. Molina Healthcare selects the facility to be accessed for the evaluation and possible transplant.

2. **Clinical Trials -** Molina Healthcare does not delegate to Providers the authority to determine and authorize clinical trials. Providers are required to comply with protocols, policies, and procedures for clinical trials as set forth in Molina Healthcare's contracts. 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 Healthcare'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.

3. **Experimental and Investigational Reviews -** Molina Healthcare does not delegate to Providers the authority to determine and authorize experimental and investigational (E & I) reviews.

H. Delegated Utilization Management Functions

Medical Groups/IPAs and delegated with UM functions must be prior approved by Molina Healthcare and be in compliance with all current Molina Healthcare policies. Molina Healthcare 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 Healthcare policies and regulatory and certification requirements.

Utilization management activities that may be delegated include:

- Inpatient admissions;
- Discharge Planning;
- Medical Case Management;
- Disease Management;
- Transition of Care When Benefits End;
- Organizational Determinations;
- Member Notification of Provider Termination (SNF, HHC, Free Standing Restorative Centers, PT, OT, ST);
- Emergency and Post-Stabilization Services; and/or

- Manage of Out-of-Area/Out-of-Network Admissions.

I. 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.

J. Inpatient Review

For selected cases, Molina Healthcare performs inpatient review to determine medical necessity and appropriateness of a continued inpatient stay. The goal of inpatient review is to identify appropriate discharge planning needs and facilitate discharge to an appropriate setting. CMS regulations, guidance and processes as well as evidence based criteria sets are used as guidelines in performing concurrent review activities.

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;
- Member appropriate for outpatient case management is identified and referred; and
- Decisions must be guided by CMS regulations, guidance and processes as well as evidence based criteria sets.
- Hospital readmissions are not avoidable or preventable.

K. Inpatient Status Determinations

Molina Healthcare follows payment guidelines for inpatient status determinations consistent with CMS guidelines and regulations.

L. 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 Healthcare 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 Healthcare on a daily basis of all hospital admissions.

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

M. 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 Healthcare with Member demographic information, date of discharge, discharge plan and disposition.

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

N. Post-Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina Healthcare 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 will be denied.

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Molina Healthcare Member or there was a Molina Healthcare 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.

O. Readmission Policy

Hospital readmissions less than thirty-one (31) calendar days from the date of discharge have been found by Centers for Medicare and Medicaid Services (CMS) to potentially constitute a quality of care problem. Readmission review is an important part of Molina Healthcare's Quality Improvement Program to ensure that Molina Healthcare Members are receiving hospital care that is compliant with nationally recognized guidelines, as well as federal and state regulations.

Molina Healthcare will conduct readmission reviews for applicable participating hospitals if both admissions occur at the same facility. If it is determined that the subsequent admission is related to the first admission ("Readmission"), the first payment may be considered as payment in full for both the first and second hospital admissions. Readmission reviews will be conducted in accordance with CMS guidelines.

P. Coordination of Care

The coordination of care process assists Molina Healthcare Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Healthcare Members whose benefits are ending and are in need of continued care.

There are two (2) coordination of care processes for Molina Healthcare Members. The first occurs when a new Member enrolls in Molina Healthcare and needs to transition medical care to Molina Healthcare contracted Providers. There are mechanisms within the enrollment process to identify those Members and reach out to them from the Member & Provider Contact Center (M&PCC) 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 Healthcare Member's benefits will be ending and they need assistance in transitioning to other care. The process includes mechanisms for identifying Molina Healthcare 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.

Q. Organization Determinations

An organization determination is any determination (e.g., an approval or denial) made by Molina Healthcare 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 Healthcare Medicare 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 Healthcare Members. As a Medicare Plan, Molina Healthcare and its delegated Medical Groups/IPAs, or other delegated entity at a minimum, cover all services and items required by Medicare.

Requests for authorization not meeting criteria must be reviewed by a designated Provider 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 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 Healthcare.

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 Healthcare 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 Healthcare'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 Healthcare 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 Healthcare.

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 the Centers for Medicare and Medicaid Services (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 Healthcare 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 Notice of Medicare Non-Coverage (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 Healthcare (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 Healthcare (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 Detailed Explanation of Non-Coverage (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 Healthcare 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.

R. Continuity of Care

Molina Healthcare and its contracted Providers must provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination:

- **Acute condition or serious chronic condition** - Following termination, the terminated Provider will continue to provide covered services to the Member up to ninety (90) days or

longer if necessary for a safe transfer to another Provider as determined by Molina Healthcare or its delegated Medical Group/IPA.

- **High risk of second or third trimester pregnancy** - The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary for a safe transfer.

S. Emergency and Post-Stabilization Services

Molina Healthcare 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 Healthcare covers maintenance care and post-stabilization services which are medically necessary, non-emergency services. Molina Healthcare 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 Healthcare 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 Healthcare requires pre-approval of further post-stabilization services by a participating Provider or other Molina Healthcare 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 Healthcare or its delegated entity is financially responsible for these services until Molina Healthcare or its delegated entity becomes involved with managing or directing the Member's care

Molina Healthcare 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 Molina Healthcare. 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.

T. Delegation Oversight of Providers Performing UM Functions

Molina Healthcare provides oversight and ongoing evaluation of those Medical Groups/IPAs and entities delegated to perform UM functions. The Delegation Oversight staff is responsible for systematic monitoring of each delegated Medical Group/IPA and entity to ensure their continued ability to perform the delegated activities. At least annually, the Delegation Oversight staff conducts an audit of each delegated entity to ensure compliance with Molina Healthcare's delegation requirements as well as adherence to all applicable regulatory and accreditation standards. A specifically designed UM audit tool is utilized for this assessment and evaluation.

1. **Initial Approval for Delegation –** In order to receive delegation status for UM activities, Provider groups and other entities must demonstrate compliance with Molina Healthcare's established UM standards. Delegation of selected functions may occur only after an initial audit of the utilization activities has been completed and there is evidence that Molina Healthcare's delegation requirements are met. Findings are presented to Molina Healthcare Committees for approval and granting of delegation status.

   A mutually agreed upon written delegation agreement describing the responsibilities of Molina Healthcare and the delegated entity will be maintained and reviewed annually. The delegation agreement includes a written description of the specific utilization delegated activities, monitoring of delegated functions, and corrective action or termination of delegated entities that fail to adequately perform delegated functions.

2. **Criteria for Delegated Utilization Management –** Molina Healthcare requires that delegated entity have a written Utilization Management Program in place which includes a detailed description of the UM program operations. The program must have documented goals and objectives, and describe the organizational structure and staffing for performing the program functions. The UM program must be approved by the delegated entity's Utilization Management Committee and/or governing board annually, and documentation of the review and approval must be submitted to Molina Healthcare. Nationally recognized UM criteria must be included in the program to ensure consistent decision making during the review process.

   Compliance with Molina Healthcare's Utilization Management Program requires delegated Medical Group/IPA and delegated entities to meet standards that include, but are not limited to the following:
   - Timely, complete and accurate response to Molina Healthcare's request for information regarding Utilization Management activities;
   - Compliance with Molina Healthcare's requirements for determining and authorizing level of care for every patient every day;
   - Active communication (daily or as requested based on the clinical condition of the Member) with Molina Healthcare staff to ensure accurate recording of authorized level of care;
   - Active collaboration and coordination with Molina Healthcare's UM staff performing concurrent review, case management and discharge planning;

- Compliance with all Molina Healthcare's data submission and reporting requirements;
- Maintenance of accurate, timely and consistently formatted medical records as requested; and
- Providers shall educate and train hospital staff and provide sufficient oversight to ensure their compliance with Molina Healthcare's UM Program requirements as they relate to prior authorization, concurrent review and discharge planning for hospitalized Members.

The delegated Provider must have an established Utilization Management Committee which meets at least quarterly to review utilization issues and determine improvement plans where indicated. Molina Healthcare representatives may attend the committee meeting, with advance notice. Minutes of the Utilization Management Committee must be made available to Molina Healthcare upon request. Molina Healthcare Delegation Oversight staff must be permitted reasonable access to the UM files, minutes and records of the provider entity for the purpose of auditing UM activities.

Delegated entities are required to provide evidence that internal procedures are operational and to take appropriate action in areas where problems are identified. These entities are responsible for providing feedback to Molina Healthcare regarding the conclusions, recommendations, actions and follow-up where problems have been identified.

U. 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.

Molina Healthcare reports suspected or potential abuse, neglect or exploitation of vulnerable adults as required by state and Federal law. A vulnerable adult is defined as a person who is not able to defend themselves, protect themselves, or get help for themselves when injured or emotionally abused. A person may be vulnerable because of a physical condition or illness (such as weakness in an older adult or physical disability) or a mental/behavioral or emotional condition. Mandatory reporters include:

- Molina Healthcare employees who have knowledge of or suspect the abuse, neglect or exploitation;
- Law enforcement officer;
- Social worker; professional school personnel; individual Provider; an employee of a facility; an operator of a facility; and/or
- An employee of a social service, welfare, mental /behavioral health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science Provider or healthcare Provider.

A permissive reporter is any individual with knowledge of a potential abuse situation who is not included in the list of mandatory reporters. A permissive reporter may report to the Molina

Healthcare UM Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited or neglected. Permissive or voluntary reporting will occur as needed.

The following are the types of abuse which are required to be reported:

- **Physical abuse** is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints.
- **Sexual abuse** is nonconsensual sexual contact. Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing.
- **Mental/behavioral mistreatment** is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; and yelling or swearing which results in mental distress.
- **Neglect** occurs when someone, either through action or inaction, deprives a vulnerable adult of care necessary to maintain physical or mental health.
- **Self-neglect** occurs when a vulnerable adult fails to provide adequately for themselves. A competent person who decides to live their life in a manner which may threaten their safety or well-being does not come under this definition.
- **Exploitation** occurs when a vulnerable adult or the resources or income of a vulnerable adult are illegally or improperly used for another person's profit or gain.
- **Abandonment** occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter or health care.

In the event that an employee of Molina Healthcare or one of its contracted providers encounters potential or suspected abuse as described above, a call must be made to:
Molina Healthcare of Florida (866)-553-9494 or Adult Protective Services (APS) Elder Abuse Hotline: (877) 4-R-SENIORS, (877) 477-3646

All reports should include:

- Date abuse occurred;
- Type of abuse;
- Names of persons involved if known;
- Source of Information;
- Names and telephone numbers of other people who can provide information about the situation; and
- Any safety concerns.

Molina Healthcare’s Interdisciplinary Care Team (ICT) 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 Healthcare 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 Healthcare will track, analyze, and report aggregate information regarding abuse reporting to the Utilization Management Committee and the proper state agency.

V. Primary Care Providers

Molina Healthcare provides a panel of Primary Care Providers (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 Healthcare. Molina Healthcare's Medicare Members are required to see a PCP who is part of the Molina Healthcare's Medicare Network. Molina Healthcare's Medicare Members may select or change their PCP by contacting the Molina Healthcare's Member & Provider Contact Center (M&PCC).

W. Specialty Providers

Molina Healthcare maintains a network of specialty Providers to care for its Members. Referrals from a Molina Healthcare 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 Healthcare 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 Healthcare UM Department. Referrals to specialty care outside the network require prior authorization from Molina Healthcare.

X. 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 healthcare 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, and referrals to community resources are made as appropriate. 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;
   - Appropriate application of benefits;
   - 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 healthcare 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;
- Attention to the handling of PHI and maintaining confidentiality;
- 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 Healthcare staff.

Y. Molina Healthcare Special Needs Plan Model of Care

1. **Targeted Population -** Molina Healthcare operates Medicare Dual Eligible Special Needs Plans (SNP) for Members who are fully eligible for both Medicare and Medicaid. In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations, Molina Healthcare has a SNP Model of Care that outlines Molina Healthcare's efforts to meet the needs of the dual eligible SNP population. 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 Healthcare Dual Eligible Special Needs Plan Model of Care addresses the needs of all sub-populations found in the Molina Healthcare Medicare SNP.

2. **Care Management Goals -** Utilization of the Molina Healthcare SNP extensive network of primary Providers, specialty Providers and facilities, in addition to services from the Molina Healthcare Medicare SNP Interdisciplinary Care Team (ICT), will improve access of Molina Healthcare Members to essential services such as medical, mental health and social services. Molina Healthcare 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 Healthcare Geo Access reports showing availability of services by geographic area;

b. Number of Molina Healthcare 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. Healthcare Effectiveness Data and Information Set (HEDIS®) use of services reports;

d. Member Access Complaint Report;

e. Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey; and

f. Molina Healthcare Provider Access Survey.

3. **Members of the Molina Healthcare SNP will have access to quality affordable healthcare.** Since Members of the Molina Healthcare 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 Healthcare focuses on delivering high quality care. Molina Healthcare has an extensive process for credentialing network Providers, ongoing monitoring of network Providers and peer review for quality of care complaints. Molina Healthcare maintains recommended clinical practice guidelines that are evidence based and nationally recognized. Molina Healthcare regularly measures Provider adherence to key provisions of its clinical practice guidelines. Molina Healthcare 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 Healthcare's network of primary care and specialty Providers as well as Molina Healthcare's programs that include Care Management, Case Management, Health Management, Service Coordination, Nurse Advice Line, Utilization

Management and Quality Improvement, **SNP Members have an opportunity to realize improved health outcomes.**

Molina Healthcare 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 Health Outcomes Survey (HOS); and
b. Chronic Care Improvement Program Reports.

5. **Molina Healthcare Members will have an assigned point of contact for their coordination of care.** According to Member need this coordination of care contact point might be their Molina Healthcare Network PCP or Molina Healthcare Case Manager. Care will be coordinated through a single point of contact who interacts with the Molina Healthcare Interdisciplinary Care Team (ICT) to coordinate care as needed.

6. **Members of the Molina Healthcare Medicare SNP will have improved transitions of care across healthcare settings, Providers and health services.** The Molina Healthcare Medicare SNP has programs designed to improve transitions of care. Authorization processes enable Molina Healthcare staff to become aware of transitions of care due to changes in healthcare status as they occur. Molina Healthcare case managers work with Members, their caregivers and their Providers to assist in care transitions. In addition Molina Healthcare 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 Member is following the prescribed discharge plan once they are home, that they have scheduled a follow up physician appointment, have filled all prescriptions, understands how to administer their medications and is receiving 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 Healthcare. Molina Healthcare 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 Healthcare Medicare SNP will have improved access to preventive health services.** The Molina Healthcare 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 Healthcare uses and publicizes nationally recognized preventive health schedules to its Providers. Molina Healthcare 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 Healthcare 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 Healthcare Medicare SNP will have appropriate utilization of healthcare services**. Molina Healthcare 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 Healthcare 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 Healthcare Over and Under Utilization Reports.

9. **Staff Structure and Roles -** The Molina Healthcare Medicare SNP has developed its staff structure and roles to meet the needs of dual eligible Special Needs Plan Members. Molina Healthcare'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 Healthcare Medicare Dual Eligible SNP. Molina Healthcare 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 Healthcare'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 Healthcare 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 (LPN/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 (RN, SW) – Identify and address issues regarding Member's medical, behavioral health care and social needs and provide care coordination and assistance in accessing community and social service resources as appropriate. Develop a care plan with Member that

focuses on Member's identified needs and personal goals. Assist 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 revision of the care plan.

iv. Complex Case Managers (RN, SW) – Identify care needs through ongoing clinical assessments of Members identified as high risk or having complex needs. Activities include coordinating services of medical and non-medical care along a continuum rather than episodic care focused on a Member's physical health care, behavioral health care, chemical dependency services, long term care, and social support needs while creating individualized care plans. Conduct health assessments and manage Member's medical, psychosocial, physical and spiritual needs – develop, implement, monitor and evaluate care plans in conjunction with Members/caregivers, their Providers and other team members. Focus is on Members with complex medical illness.

v. Health Manager – Develop materials for Health Management Care Levels, serve as resource for Members and Molina Healthcare staff members regarding Health Management Program information, educates Members on how to manage their condition.

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

vii. Community Connectors/Health Workers – the Community Connectors are community health workers trained by Molina Healthcare 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.

viii. Behavioral Health Team includes Molina Healthcare 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 Care Access and Monitoring Teams and providers regarding Member's behavioral health care needs and care plans.

b. **Member & Provider Contact Center (M&PCC)** – Serves as a Member's initial point of contact with Molina Healthcare and main source of information about utilizing the Molina Healthcare 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 Healthcare 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 and credentialing program, provide and interpret reporting on QI Program, evaluate QI Program, and 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.

v. Credentialing Specialist – Gather data and reporting for credentialing function.

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 Healthcare'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 Healthcare 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 Healthcare'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 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 Healthcare 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 healthcare reporting and analysis program, oversight of clinical aspects of Part C Quality Reporting, oversight of healthcare analysts.

i. **Health Management Team** is a Molina Healthcare care team that provides multiple services to Molina Healthcare's Medicare SNP Members. This team provides population based Health Management Programs for low risk Members identified with asthma, diabetes, COPD and cardiovascular disease. 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:
The following is a description of the composition of the ICT and how membership on the team is determined. The Molina Healthcare Medicare SNP Interdisciplinary Care Team (ICT) is the core of Molina Healthcare's Integrated Care Management Program. Molina Healthcare chooses ICT membership based on those health care professionals who have the most frequent contact with the Members and the most ability to implement Model of Care components in the Member's care. The ICT is typically composed of the Member's assigned PCP and the Molina Healthcare assigned Case Manager and Molina Healthcare Medical Director. The Member can select other participants such as their caregiver, specialist or family. The composition of this team is designed to address all aspects of a Member's healthcare including medical, behavioral and social health. Additional members of the ICT may be added on a case by case basis depending on a Member's conditions and health status.

ii. Additional positions that may be included (either temporarily or permanently) to the Molina Healthcare Medicare SNP ICT caring for Members include:

- Molina Healthcare Medical Directors
- Molina Healthcare Behavioral Health Specialists
- Molina Healthcare Pharmacists
- Molina Healthcare Care Transitions Coaches
- Molina Healthcare Community Connectors/Health Workers
- Network Medical Specialty Providers
- Network Home Health Providers
- Network Acute Care Hospital Staff
- Network Skilled Nursing Facility Staff
- Network Long Term Services and Supports Staff
- Network Certified Outpatient Rehabilitation Staff
- Network Behavioral Health Facility Staff
- Network Renal Dialysis Center Staff
- Out of Network Providers or Facility Staff (until a Member's condition of the state of the Molina Healthcare Network allows safe transfer to network care)

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

- Member has been stratified to a Level 3 (Complex Case Management, Care Management Level) in the assessment process.
- 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.
- Member has significant complex or unresolved mental health diagnoses.
- Member has significant complex or unresolved pharmacy needs.

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

- 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 Healthcare Staff.
- Discussions about their health care with their assigned Molina Healthcare Integrated Care Management Team members.
- Discussions with Molina Healthcare Staff in the course of Health Management programs, preventive healthcare outreach, Care Transitions program and other post hospital discharge outreach.

- Discussion with Molina Healthcare 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.

v. ICT Operations and Communication:
The Molina Healthcare Medicare SNP Member's assigned PCP and the Molina Healthcare 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 Healthcare Network. The Molina Healthcare Integrated Care Management Team will also provide assessments, care plan development and individualized care goals.

vi. The Integrated Care Management Team will be primarily involved during assessment periods, individualized care plan follow-up, during transitions of care settings, during routine case management follow-up, after referral from other Molina Healthcare Staff (i.e. Health Management Program staff, Pharmacists), requests for assistance from PCPs and requests for assistance from Members/caregivers and during significant changes in the Member's health status. 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 condition or need). The PCP and Integrated Care Management Team will decide when additional ICT members are necessary and invite their participation on an as needed basis as previously documented.

vii. The ICT will hold regular case conferences for Members with complex healthcare needs and/or complex transition issues. Members will be chosen for case conferences based on need as identified by the Molina Healthcare 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 ICT will keep minutes of the case conferences and will provide a case conference summary for each Member case discussed. Case conference summaries will be provided to all ICT members and the involved Member/caregiver.

viii. Communication between ICT members will be compliant with all applicable HIPAA regulations and will occur in multiple ways including:
- Integrated Care Management Team to acquire and review Member's medical records from Providers on the ICT before, during and after transitions in care and during significant changes in the health status of Members.
- Integrated Care Management Team to acquire and review Member's medical records from Provider members of the ICT during authorization process for those medical services that require prior authorization:
  - Integrated Care Management Team to acquire and review Member's medical records from Provider members of the ICT during the course of regular case management activities
  - Verbal or written communication between PCP and Integrated Care Management Team may occur during PCP participation in ICT Case Conferences on an as needed basis.
  - Written copies of assessment documents from Integrated Care Management Team to PCP by request and on an as needed basis.
  - Written copies of individualized care plan from Integrated Care Management Team to PCP (and other Providers as needed).
  - Case conference summaries.
- Member care plans are reviewed at least annually by professional clinical Molina Healthcare staff members in conjunction with annual Comprehensive Health Risk Assessments. Additional opportunities for review and revision of care plans may exist when Molina Healthcare Integrated Care Management Team members are aware of Member transitions in healthcare settings or significant changes in Member health care status.
- The plan of care is documented, reviewed and revised in the Clinical Care Advance system using template driven data entry to assure accuracy and completeness of care plans.

10. **Provider Network -** The Molina Healthcare 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 Healthcare's network is designed to provide access to medical care for the Molina Healthcare Medicare SNP population.

The Molina Healthcare 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 Healthcare 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 Healthcare determines Provider and facility licensure and competence through the credentialing process. Molina Healthcare has a rigorous credentialing process for all providers and facilities that must be passed in order to join the Molina Healthcare's Medicare SNP Network. The Molina Healthcare 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 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 Healthcare Professional Review Committee (PRC). The PRC consists of Molina Healthcare Network physicians who are in active practice as well as Molina Healthcare 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 Healthcare 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 healthcare 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 Healthcare Care Management Team will assist Providers and Members in determining medical necessity, available network resources (and out of network resources where necessary). The Molina Healthcare Care Management portion of the ICT will assist in finding access when difficulties arise for certain services.

A primary way that the Molina Healthcare Provider Network coordinates with the ICT is via the Molina Healthcare Medicare SNP Prior Authorization process. Molina Healthcare's Medicare SNP Prior Authorization requirements have been designed to identify Members who are experiencing transitions in healthcare settings or have complex or unresolved healthcare needs. Molina Healthcare Members undergoing transitions in healthcare settings or experiencing complex or unresolved healthcare 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 Healthcare Care Management Team. Molina Healthcare'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 Healthcare 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 Healthcare Medicare SNP regularly audits the completeness of PCP medical records utilizing the annual PCP Medical Record Review process. The Molina Healthcare 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 healthcare status or healthcare setting and to update care plans. A copy of the care plan will be provided to the PCP.

The Molina Healthcare 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 Healthcare 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 Healthcare Medicare SNP will use nationally recognized, evidence based clinical practice guidelines. Molina Healthcare 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 Healthcare website. Molina Healthcare 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 Healthcare 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 Healthcare 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 Healthcare Providers have access to SNP Model of Care training via the Molina Healthcare's website. Providers may also participate in webinar or in person training sessions on the SNP Model of Care. Molina Healthcare 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 Healthcare Provider Services Department will identify key groups that have large numbers of Molina Healthcare'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 Healthcare Services Program Director or Medical Director. Implementation and oversight of completion of training will be the responsibility of a designated Molina Healthcare Compliance staff (employees) and a designated Molina Healthcare Provider Services staff (Providers). Employees will be required to complete training or undergo disciplinary action in accordance with Molina Healthcare policies on completion of required training.

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

    a. Molina Healthcare utilizes state of the art telephonic communications systems for telephonic interaction between Molina Healthcare staff and all other stakeholders

with capabilities for call center queues, call center reporting, computer screen sharing (available only to Molina Healthcare staff) and audio conferencing. Molina Healthcare 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 healthcare reminders. Electronic fax capability and Molina Healthcare'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 Healthcare record.

b. For communication of a general nature Molina Healthcare uses newsletters (Provider and Member), the Molina Healthcare website and blast fax communications (Providers only). Molina Healthcare 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 Healthcare has available audio conferencing and audio video conferencing (Molina Healthcare 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 Healthcare.

g. Molina Healthcare Quality Improvement Committees and Sub-Committees will meet regularly on a face-to-face basis with 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 Clinical Care Advance 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 Healthcare 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 Healthcare Committee meetings will result in official meeting minutes which will be archived for future reference.

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

13. **Performance and Health Outcomes Measurement -** Molina Healthcare collects, analyzes reports and acts on data evaluating the Model of Care. To evaluate the Model of Care, Molina Healthcare 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. SF12v2™ Survey Results
    q. Case Management Satisfaction Survey

Molina Healthcare 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 Healthcare's Case Management Program.

Molina Healthcare 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 Healthcare 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 Healthcare will use the above data collection, analysis and reporting to develop a comprehensive evaluation of the effectiveness of the Molina Healthcare Model of Care. The evaluation will include identifying and acting on opportunities to improve the program. A designated Molina Healthcare Quality Improvement Director and/or Medical Director will have responsibility for monitoring and evaluating the Molina Healthcare SNP Model of Care. Molina Healthcare 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 Healthcare SNP will identify vulnerable sub-populations including frail/disabled, multiple chronic conditions, 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 Healthcare SNP Model of Care by early identification and higher stratification/priority in Molina Healthcare 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 healthcare status.

9. Member Rights and Responsibilities

Molina Healthcare Members have certain rights to help protect them. In this chapter, Member rights and responsibilities are outlined based on Molina Healthcare of Florida, Inc.'s Evidence of Coverage document that Members receive annually.

A. Molina Healthcare Members have a right to:

Have information provided in a way that works for them (in languages other than English that are spoken in our service area, in Braille, in large print or other alternate formats. To get information from us in a way that works for Members, please call Member & Provider Contact Center (M&PCC) at **(866) 553-9494.** Molina Healthcare plans have translation services available to answer questions from non-English speaking Members and can also provide information in Braille, in large print, or other alternate formats. If Members are eligible for Medicare because of disability, Molina Healthcare is required to give information about the plan's benefits that is accessible and appropriate for them.

1. **Be treated with fairness and respect at all times.** Molina Healthcare must obey laws that protect Members from discrimination or unfair treatment and not discriminate based on a race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

2. **If Members want more information or have concerns** about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights (800) 368-1019 (TTY 1-800-537-7697)** or their local Office for Civil Rights. If Members have a disability and need help with access to care, please call Member & Provider Contact Center (M&PCC) at **(866) 553-9494.** If Members have a complaint, such as a problem with wheelchair access, Member & Provider Contact Center (M&PCC) can help.

3. **Get timely access to covered services and drugs.** Members have the right to choose a Primary Care Provider (PCP) in the Molina Healthcare Medicare network to provide and arrange for covered services. Members may call Member & Provider Contact Center (M&PCC) at **(866) 553-9494** to learn which doctors are accepting new patients. Members also have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to **get appointments and covered services from the plan's network of Providers within a reasonable amount of time**. This includes the right to get timely services from specialists. Members also have the right to get prescriptions filled or refilled at any network pharmacies without long delays. If Members think that they are not getting medical care or Part D drugs within a reasonable amount of time, they may call **(800) 665-0898.**

4. **Have their privacy and personal health information protected.** Federal and State Laws protect the privacy of medical records and personal health information. Molina Healthcare protects personal health information as required by these Laws.

- A Member's "personal health information" includes the personal information given when they enrolled in this plan as well as medical records and other medical and health information.
- The Laws that protect a Member's privacy give them rights related to getting information and controlling how health information is used. Members are given a written notice, called a "Notice of Privacy Practices," that tells about these rights and explains the protection of the privacy of their health information.

5. **Be given information about our plan, our network of Providers and covered services.** Members have the right to get several kinds of information by calling Member & Provider Contact Center (M&PCC) at **(866) 553-9494.**

   - Information about Molina Healthcare, including for example, information about Molina Healthcare's financial condition. It also includes information about the number of appeals made by Members and the plan's performance ratings, including how it has been rated by plan Members and how it compares to other health plans.

   - Information about our network Providers including our network pharmacies. For example, Members have the right to get information about the qualifications of the Providers and pharmacies in the Molina Healthcare Medicare network and how Providers are paid. For more detailed information about Providers or pharmacies, Members may call Member & Provider Contact Center (M&PCC) at **(866) 553-9494** or visit our website at www.MolinaHealthcare.com.

   - Information about coverage and rules to follow in using coverage. Members are provided with what medical services are covered, any restrictions to their coverage, and what rules must be followed to get covered medical services.

   - Information about why something is not covered and what can be done about it.

6. **Be supported in their right to make decisions about their care and to know about all of their treatment choices in a way they can understand.** Members have the right to be told about all of the treatment options that are recommended for their condition, no matter what they cost or whether they are covered. It also includes being told about programs offered to help Members manage their medications and use drugs safely.

   - **Know about the risks.** Members have the right to be told about any risks involved in their care; be told in advance if any proposed medical care or treatment is part of a research experiment and they always have the choice to refuse any experimental treatments.

   - **The right to say "no."** They have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. They also have the right to stop taking medication. Of

course, if they refuse treatment or stop taking medication, they accept full responsibility for what happens to their body as a result.

- **Receive an explanation if they are denied coverage for care.** They have the right to receive an explanation from **Molina Healthcare** if a Provider has denied care that they believe they should receive.

- **Have the right to give instructions about what is to be done if they are not able to make medical decisions for themselves through an advance directive.** According to Law, no one can deny them care or discriminate against them based on whether or not they have signed an advance directive. If a Member has signed an advance directive, and they believe that a doctor or hospital hasn't followed the instructions in it, a complaint may be filed with:

  Florida Department of Elder Affairs
  Tel: (850) 414-2000
  Fax: (850) 414-2004

7. **Make complaints and to ask us to reconsider decisions we have made.** If Members have any problems or concerns about their covered services or care, they may need to ask Molina Healthcare to make a coverage decision, make an appeal to change a coverage decision, or make a complaint. Whatever they do – ask for a coverage decision, make an appeal, or make a complaint – **Molina Healthcare is required to treat them fairly.** They have the right to get a summary of information about the appeals and complaints that other Members have filed in the past. To get this information, please call Member & Provider Contact Center (M&PCC) at **(866) 553-9494.**

B. Additional Information about Members' Rights:

What can Members do if they think they are being treated unfairly or their rights are not being respected? If Members think they have been treated unfairly or their rights have not been respected due to race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, they should call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** or **TTY 1-800-537-7697**, or call the local Office for Civil Rights.

If Members think they have been treated unfairly or their rights have not been respected, *and* their issue is *not* about discrimination, they can get help dealing with the problem they are having by calling:

1. **Molina Healthcare Member & Provider Contact Center (M&PCC) at (866) 553-9494.**
2. **The State Health Insurance Assistance Program**, which is a government program with trained counselors in every state. In Florida, the State Health Insurance Assistance Program is called:
   Florida Department of Elder Affairs: Tel: (850) 414-2000; Fax: (850) 414-2004.
3. **Medicare -** Members may visit the Medicare website www.medicare.gov to read or download the publication "Their Medicare Rights & Protections;" or, Members can call

1-800-MEDICARE (1-800-633-4227) twenty-four (24) hours a day, seven (7) days a week. TTY users should call **1-877-486-2048**.

C. Molina Healthcare Members have a responsibility to:

1. Get familiar with their covered services and the rules they must follow to get these covered services.

2. Inform Molina Healthcare if they have any other health insurance coverage or prescription drug coverage.

3. Tell their doctor and other healthcare Providers that they are enrolled in Molina Healthcare, and show how their plan membership card and their Medicaid card whenever they get their medical care or Part D prescription drugs.

4. Help their doctors and other Providers help them by giving them information, asking questions and following through on their care.

5. **Be considerate.** We expect all our Members to respect the rights of other patients. We also expect them to act in a way that helps the smooth running of their doctor's office, hospitals, and other offices.

6. **Pay what they owe.** As a plan Member, they are responsible for these payments:
   - They must pay any applicable premiums for some of their medical services or drugs covered by the plan. Some Members must pay Part A and B premiums.
   - They must pay their share of the cost when they get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost).
   - If they get any medical services or drugs that are not covered by Molina Healthcare or by other insurance they may have, they must pay the full cost. If they disagree, they may appeal.
   - If they are required to pay a late enrollment penalty, they must pay it to remain a Member of Molina Healthcare.

7. **Tell Molina if they move.** If they are going to move, it is important to tell us right away.
   - If they move outside of Molina Healthcare's service area, they cannot remain a Member.
   - If they move within our service area, we still need to know so we can keep their membership record up to date and know how to contact them.

8. **Call Member & Provider Contact Center (M&PCC) for help if they have questions or concerns.** We also welcome any suggestions they may have for improvement. Member & Provider Contact Center (M&PCC) can be reached at **(866) 553-9494**

10. Provider Responsibilities

A. Provision of Covered Services

Providers will render covered services to Members within the scope of the Provider's business and practice, in accordance with the Provider's contract, Molina Healthcare's policies and procedures, the terms and conditions of the Molina Healthcare's Medicare product which covers the Member and the requirements of any applicable government-sponsored program.

B. Standard of Care

Providers will render covered services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct and any controlling governmental licensing requirements.

C. Facilities, Equipment and Personnel

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

D. Referrals

When a Provider determines that it is medically necessary to consult or obtain services from other specialty health professionals, the Provider should make a referral in accordance with **Section 8 – Utilization Management** of this Manual unless the situation is one involving the delivery of emergency services. Providers should coordinate the provision of specialty care in order to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested and diagnosis for which the referral is being made.

E. Contracted Providers

Except in the case of emergency services or after receiving prior authorization from Molina Healthcare, Providers should direct Members to use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and Providers, which have contracted with the Molina Healthcare Medicare Program.

F. Member Eligibility Verification

Providers should verify eligibility of Molina Healthcare Members prior to rendering services. Options Plus (HMO SNP) Members may switch health plans at any time during the year.

G. Admissions

Providers are required to comply with Molina Healthcare's facility admission and prior authorization procedures.

H. Prescriptions

Providers are required to abide by Molina Healthcare drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Providers should obtain prior authorization from the Molina Healthcare Pharmacy Department if the provider believes it is necessary to prescribe a non-formulary drug or a brand name drug when generics are available.

The only exceptions are prescriptions and pharmaceuticals ordered for inpatient facility services. Molina Healthcare's contracted pharmacies/pharmacists may substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

I. Subcontract Arrangements

Any subcontract arrangement entered into by a Provider for the delivery of covered services to Members must be in writing and will bind the Provider's subcontractors to the terms and conditions of the Provider's contract including, but not limited to, terms relating to licensure, insurance, and billing of Members for covered services.

J. Availability of Services

Providers must make necessary and appropriate arrangements to assure the availability of covered services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member visits after hours. Providers are to meet the applicable standards for timely access to care and services as outlined in this manual in Section 6 – Quality Improvement, taking into account the urgency of the need for the services.

K. Treatment Alternatives and Communication with Members

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

L. Nondiscrimination

Providers will not differentiate or discriminate in providing covered services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual

orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed healthcare programs. Providers are to render covered services to Members in the same location, in the same manner, in accordance with the same standards and within the same time availability regardless of payer.

M. Maintaining Member Medical Record

Providers are to maintain an accurate and readily available medical record for each Member to whom health care services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record should contain all information required by State and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina Healthcare's policies and procedures. Providers are to retain all such records for at least ten (10) years.

N. Confidentiality of Member Health Information

Providers are expected to comply with all applicable State and Federal Laws. Refer to Section 7 for HIPAA requirements and information.

O. HIPAA Transactions

Providers are expected to comply with all HIPAA TCI (transactions, code sets, and identifiers) regulations. Refer to Section 7for HIPAA requirements and information.

P. National Provider Identifier (NPI)

Providers are expected to comply with all HIPAA NPI regulations. Refer to Section 7 - HIPAA requirements and information.

Q. Delivery of Patient Care Information

Providers are to promptly deliver to Molina Healthcare, upon request and/or as may be required by State or Federal Law, Molina Healthcare's policies and procedures, applicable government sponsored health programs, Molina Healthcare's contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by the Provider, including but not limited to, any and all information requested by Molina Healthcare in conjunction with utilization review and management, grievances, peer review, HEDIS® Studies, Molina Healthcare's Quality Improvement Program, or claims payment. Providers will further provide direct access to patient care information as requested by Molina Healthcare and/or as required to any governmental agency or any appropriate State and Federal authority having jurisdiction. Molina Healthcare will have the right to withhold compensation from the Provider in the event that the Provider fails or refuses to promptly provide any such information to Molina Healthcare.

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.

R. Member Access to Health Information

Providers are expected to comply with all applicable State and Federal Laws. Refer to Section 7 for HIPAA requirements and information.

S. Participation in Grievance Program

Providers are expected to participate in Molina Healthcare's Medicare Grievance Program and cooperate with Molina Healthcare 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 would participate by providing medical records or statement if needed. Please refer to Section 14 regarding Member appeals and grievances.

T. Participation in Quality Improvement Program

Providers are expected to participate in Molina Healthcare's Quality Improvement Program and cooperate with Molina Healthcare in conducting peer review and audits of care rendered by Providers.

U. Participation in Utilization Review and Management Program

Providers are required to participate in and comply with Molina Healthcare's utilization review and management programs, including all policies and procedures regarding prior authorizations, Providers will also cooperate with Molina Healthcare in audits to identify, confirm, and/or assess utilization levels of covered services.

V. Participation in Credentialing

Providers will participate in Molina Healthcare's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina Healthcare. The Provider is to immediately notify Molina Healthcare of any change in the information submitted or relied upon by the Provider to achieve credentialed status. If the Provider's credentialed status is revoked, suspended or limited by Molina Healthcare, Molina Healthcare may, at its discretion, terminate the contract and/or reassign Members to another Provider.

W. Delegation

The delegated entities will accept delegation responsibilities at Molina Healthcare's request and shall cooperate with Molina Healthcare in establishing and maintaining appropriate mechanisms within the Provider's organization. If delegation of responsibilities is revoked, Molina

Healthcare will reduce any otherwise applicable payments owing to the delegated entity. Delegated services may include but not be limited to Claims, Utilization Management, Credentialing, and certain administrative functions that meet the criteria for delegation.

Delegated entities shall comply with all State and Federal requirements including but not limited to:

- Reporting.
- Timeliness standards for organizational determinations.
- Training and education.

X. Provider Manual

Providers will comply and render covered services in accordance with the contents, instructions and procedures as outlined in this manual, which may be amended from time to time at Molina Healthcare's sole discretion.

Y. Health Education/Training

Providers are to participate in and cooperate with Molina Healthcare Provider education and training efforts as well as Member education and efforts. Providers are also to comply with all Molina Healthcare's health education, cultural and linguistic standards, policies, and procedures.

Z. Promotional Activities

At the request of Molina Healthcare, the Provider may display Molina Healthcare promotional materials in its offices and facilities as practical, and cooperate with and participate in all reasonable Molina Healthcare marketing efforts. Providers shall not use Molina Healthcare's name in any advertising or promotional materials without the prior written permission of Molina Healthcare.

Providers are responsible for complying with all Marketing Guidelines. The provisions that apply to Providers are identified in the Guidelines. CMS periodically updates and revises the Guidelines. Providers should keep apprised of any updates that are issued by CMS. For your convenience, we have provided the following link to CMS's website:
http://www.cms.hhs.gov/manuals/downloads/mc86c03.pdf

AA. Electronic Solutions Participation

Molina Healthcare encourages Providers to utilize electronic solutions and tools whenever possible. Molina Healthcare offers a number of electronic solutions to our Providers. These tools are intended to improve Provider access to information related to Molina Healthcare Members, and increase the level of services and support received by providing faster turn-around-times and creating efficiencies.

Electronic Tools/Solutions available to providers include:

- Provider Web Portal

- Electronic Claims Submission Options
- Electronic Payment (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)

Provider Web Portal: Molina Healthcare's Provider Web Portal (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
- Claims Functions
  - Submit Professional and Institutional Claims (single or in batch)
  - Receive notification of Claims status change
  - Correct Claims
  - Void Claims
  - Add attachments to previously submitted claims
  - Check Claims status
  - Export Claims reports
- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization Requests
  - Check status of Authorization Requests
  - Receive notification of change in status of Authorization Requests
- View HEDIS® Scores and compare to national benchmarks

Electronic Claims Submission: Molina Healthcare encourages providers to submit claims electronically. Electronic claims submission provides significant benefits to the provider including:
- Reduction in operational costs associated with paper claims (printing, postage, etc.)
- Ensures HIPAA Compliance
- Increased accuracy of data and efficient information delivery
- Reduction in claims delays (since errors can be corrected and re-submitted electronically)
- Claims reach Molina Healthcare faster, since there is no mailing time

Molina Healthcare offers the following electronic Claims submission options:
- Submit Claims to Molina Healthcare via your regular EDI clearinghouse using **Payer ID number 51062.**
- Submit Claims directly to Molina Healthcare of Florida, Inc. via the Provider Portal.

For more information on EDI Claims submission, see the Section 11, Claims and Compensation of this Provider Manual.

Electronic Payment: Providers are encouraged 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 Healthcare 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.

11. Claims and Compensation

When billing for services rendered to Molina Healthcare Members, Providers must bill with the most current Medicare-approved coding (CMS approved diagnostic and procedure code, CPT, HCPCS, etc.) available. Claims must be submitted using the proper claim form/format, e.g., for paper claims a CMS1500 or UB04, and for an electronically submitted claim – in approved ANSI/HIPAA format.

It is recommended that claims be submitted as if they are being billed to Medicare fee-for-service. The following information must be included on every claim:

A. Data Elements Required

- Member name, date of birth and Molina Healthcare 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 (Box 32 of CMS 1500 form)

Molina Healthcare will process only legible claims. Handwritten claims are not acceptable and will be rejected. Incomplete, inaccurate, or untimely re-submissions may result in denial of the claim.

Please submit paper claims to Molina Healthcare office at the following address:

Molina Healthcare Medicare Claims
PO Box 22811
Long Beach, CA 90801

To overnight claims (physical address):

Molina Healthcare Inc.
Medicare Claims Processing
200 Oceangate, Suite 100
Long Beach, CA 90802

B. Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would reduce reimbursement for certain conditions that occur as a direct result of a hospital stay. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

Hospital Acquired Conditions include the following events occurring during a hospital stay:

- Catheter-associated urinary tract infection (UTI).
- Pressure ulcers (bed sores).
- Serious preventable event – object left in during surgery.
- Serious preventable event – air embolism.
- Serious preventable event – blood incompatibility.
- Vascular catheter-associated infections.
- Mediastinitis after coronary artery bypass graft surgery (CABG).
- Hospital-acquired injuries – fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes.

The HAC/POA program was implemented by Medicare in the following stages:

- October 1, 2007 – Medicare required Inpatient Prospective Payment System (IPPS) hospitals to submit POA indicators on diagnoses for inpatient discharges.
- April 1, 2008 – Medicare started returning claims with no payment if the POA indicator is not coded correctly (missing POA indicators, invalid POA indicators or inappropriate POA coding on POA-exempt diagnosis codes).
- October 1, 2008, hospitals no longer received additional payments for conditions acquired during the patient's hospitalization.

Effective for inpatient discharges on or after January 20, 2009, Molina Healthcare adopted the Medicare HAC/POA program. What this means to Providers:

- Acute Inpatient Prospective Payment System (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/

C. Claims Submission Questions

Molina Healthcare is concerned that all Provider questions and concerns about claims are answered timely. Please refer to contact information above and in Section 3.

D. Electronic Claim Submissions

Molina Healthcare uses numerous clearing houses for electronic submissions of CMS1500s and facility/institutional claims. You can contact your local Provider Service Representative for the lists of clearing houses. **Please use Molina Healthcare of Florida, Inc., Payer ID number 51062, when submitting claims electronically.**

Molina Healthcare encourages Providers to track all electronic submissions using the acknowledgement reports received from the Provider's current clearing house. These reports assure claims are received for processing in a timely manner. Additionally, Emdeon/Change Healthcare clearing house issues an acknowledgement report to the submitting Provider within five (5) to seven (7) business days of claim transmission. Any problems experienced with claims transmission should be addressed to the Provider's current clearinghouse representative.

E. Timely Claim Filing

Claims for covered services rendered to Molina Healthcare Members must be filed within one (1) calendar year after the date of service.

F. Timely Claims Processing

A complete claim is a claim that has no defect, impropriety, lack of any required substantiating documentation as outlined in Part A above, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. All hard copy claims received by Molina Healthcare will be clearly stamped with date of receipt. Claim payment will be made to contracted Providers in accordance with the timeliness standards set forth by the Centers for Medicare and Medicaid Services (CMS).

G. Billing Options/ Molina Members

1. Providers contracted with Molina Healthcare 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.

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

3. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina Healthcare 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.

4. Provider agrees to accept payment from Molina Healthcare as payment in full, or bill the appropriate responsible party, for any Medicare Part A and B cost sharing that is covered by Medicaid.

5. Provider may not bill a Molina Healthcare 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 Healthcare and has documentation.
   - The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.
     - A Member is responsible for payment of a hospital outpatient emergency room visit if it is determined that an emergency did not exist at the time the service was provided except in those circumstances in which the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of medical attention could reasonably be expected by a prudent layperson to result in placing the Member's health in jeopardy, impairment or dysfunction. The Member may only be billed for the emergency room charges, but cannot be billed for the ancillary charges (e.g., laboratory & radiology services)

H. Provider Claim Redeterminations

Providers seeking a redetermination of a claim previously adjudicated must request such action within one-hundred-twenty (120) days of Molina Healthcare original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following:

- Requests must be fully explained as to the reason for redetermination.
- Previous claim and remittance advice, any other documentation to support the request and a copy of the referral/authorization form (if applicable) must accompany the request.
- Requests for claim redetermination should be mailed to the address referenced at the end of this section.
- Corrected claim submissions are not adjustments and should be directed through the original submission process marked as a corrected claim or it will result in the claim being denied.

I. Overpayments and Refund Requests

In the event Molina Healthcare finds an overpayment on a claim or must recoup money, the Provider will be mailed a letter requesting a refund of the overpayment. The Provider has sixty (60) calendar days to refund Molina Healthcare. If the refund is not received within that time, the amount overpaid will be deducted from the Provider's next claim payment.

All questions pertaining to refund requests are to be directed to the Claims Customer Service Department **toll free at (866)-642-8999.**

J. Third Party Liability (TPL)/Coordination of Benefits (COB)

For Members enrolled in a Molina Healthcare plan, Molina Healthcare and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these Members. Molina

Healthcare will pay claims for covered services; however if TPL/COB is determined Molina Healthcare may cost avoid if appropriate or request recovery post payment. Molina Healthcare will attempt to recover any overpayments paid as the primary payer when another insurance is primary.

K. Medicaid coverage for Molina Healthcare Medicare Members

There are certain benefits that will not be covered by Molina Healthcare 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 Healthcare 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 Healthcare 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 Healthcare's contracted allowable rate the claim is considered paid in full and zero dollars will be applied to claim.

L. Provider Claims Appeal Claims Process

The Provider Appeal/Dispute Claims Review process, which differs from the Member appeals process, offers recourse for Providers, who are dissatisfied with a claim denial or decision. Molina Healthcare of Florida, Inc. will consider requests that are submitted by either the Provider directly or by parties acting on behalf of the Provider (such as attorneys and collection agencies). Provider Appeal requests must be submitted to Molina Healthcare of Florida, Inc. within one-hundred-twenty (120) days of the initial Remittance.

The party requesting an appeal must submit a letter to Molina Healthcare clearly identified as "Claim Appeal Request." The written correspondence must refer to the claim number.

Provider Appeal/Dispute requests must include all pertinent information such as:

- The original claim;
- Prior authorization letter;
- Claim denial letter;
- Supporting medical records; and
- Any new information pertinent to the Denied Claims Review request.

Requests submitted without this documentation may be delayed. Requests submitted more than one-hundred-twenty (120) days from the original decision may be denied. Request for Denied Claims Review should be mailed to the address specified in Section A above.

The Provider will be notified of Molina Healthcare of Florida, Inc. decision in writing within sixty (60) calendar days of receipt of the Claims Appeals/Dispute request. Providers may **not** "bill" the Member when a denial for covered services is upheld per review. A redetermination request, which differs from "Provider Appeals/Dispute" request, must be submitted within one-hundred-twenty (120) days of the original RA from Molina Healthcare in order to be considered.

Providers may request a claim redetermination when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

If the Provider has a direct contract with the delegated medical group/IPA, the Provider must make an initial review request or a claim adjustment request through that group.

M. Claims Review and Audit

Providers acknowledge Molina Healthcare's right to review Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to:

- Current UB manual and editor;
- Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding;
- CMS billing and payment rules;
- National Correct Coding Initiatives (NCCI) Edits; and
- FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices.

Providers acknowledge Molina Healthcare's right to conduct such review and audit on a line-by-line basis or on such other basis as Molina Healthcare deems appropriate and Molina Healthcare's right to adjust the bill to pay the revised allowable level.

Providers acknowledge Molina Healthcare's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. The Provider shall cooperate with Molina Healthcare's audits of claims and payments by providing access to:

- Requested claims information;
- All supporting medical records;
- Provider's charging policies; and
- Other related data.

Molina Healthcare will use established industry claims adjudication and/or clinical practices, State and Federal guidelines, and/or Molina Healthcare's policies and data to determine the appropriateness of the billing, coding and payment.

N. Oversight and Monitoring of Delegated Medical Groups/IPA – Claims and Financial Reporting

Molina Healthcare routinely monitors its network of delegated Medical Groups/IPAs and other delegated entities for compliance with various standards. These requirements include, but are not limited to:

1. **Claims Timeliness Reporting/Audits** – Molina Healthcare requires delegated Medical Group/IPAs and other delegated entities to submit monthly claims processing reports. These reports are due to Molina Healthcare by the fifteenth (15^{th}) of each month for all claims processed in the previous month.

- 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.

Molina Healthcare requires the Medical Groups/IPAs and other delegated entities to achieve passing claims audit scores. Claims audits are conducted annually. More frequent audits are conducted when the Medical Group/IPA and other delegated entities does not achieve the timely processing requirements referenced above.

2. **Encounter Data Reporting -** Molina Healthcare will accept encounter data via hard copy (CMS1500 or UB04) or electronically (in specified formats). Electronic encounter data is due to Molina Healthcare by the fifth (5^{th}) day of the second month following the encounter (e.g., by August 5th for encounters occurring in June).

   Hard copy encounter data is due to Molina Healthcare within ninety (90) days from the end of the month following the encounter (e.g., by October 31st for all encounters occurring in July).

O. Provider Reconsideration of Delegated Claims

Providers requesting a reconsideration, correction or reprocessing of a claim previously adjudicated by an entity that is delegated for claims payment must submit their request to the delegated entity responsible for payment of the original claim.

12. Fraud, Waste and Abuse Program

A. Introduction

Molina Healthcare is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina Healthcare's Compliance department maintains a comprehensive plan, which addresses how Molina Healthcare will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste, and abuse. Molina Healthcare's Special Investigation Unit (SIU) supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations to identify and report findings to the appropriate regulatory and/or law enforcement agencies.

B. Definitions

1. **Fraud:** Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. § 1347.

2. **Waste:** Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

3. **Abuse:** Actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

C. Mission

Molina Healthcare 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 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.

D. Compliance Department Contact Information

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 Global Compliance, 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 Global Compliance 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 **(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's Medicare Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation. 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.

To report fraud, waste, and abuse by mail, send to:

Confidential
Medicare Compliance Official
Molina Healthcare
200 Oceangate, Suite 100
Long Beach, CA 90802

E. Regulatory Requirements

1. **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, healthcare 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.

2. **Deficit Reduction Act -** The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs. Healthcare entities like Molina

Healthcare who receive or pay out at least five million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina Healthcare, Providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds 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 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 (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 Healthcare will take steps to monitor Molina Healthcare contracted Providers to ensure compliance with the law.

3. **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.

4. **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 Practitioners.

5. **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.

F. Examples of Fraud, Waste and Abuse by a Provider

The types of questionable Provider schemes investigated by Molina Healthcare include, but are not limited to the following:

1. Altering claim forms, electronic claim forms, and/or medical record documentation in order to get a higher level of reimbursement.

2. Balance billing a Medicare and/or Medicaid Member for Medicare and/or Medicaid 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.

3. Billing and providing for services to Members that are not medically necessary.

4. Billing for services, procedures and/or supplies that have not been rendered.

5. Billing under an invalid place of service in order to receive or maximize reimbursement.

6. Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.

7. Concealing a Member's misuse of a Molina Healthcare identification card.

8. Failing to report a Member's forgery or alteration of a prescription or other medical document.

9. False coding in order to receive or maximize reimbursement.

10. Inappropriate billing of modifiers in order to receive or maximize reimbursement.

11. Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.

12. Knowingly and willfully referring patients to health care facilities in which or with which the physician has a financial relationship for designated health services (The Stark Law).

13. Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.

14. Not following incident to billing guidelines in order to receive or maximize reimbursement.

15. Overutilization

16. Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.

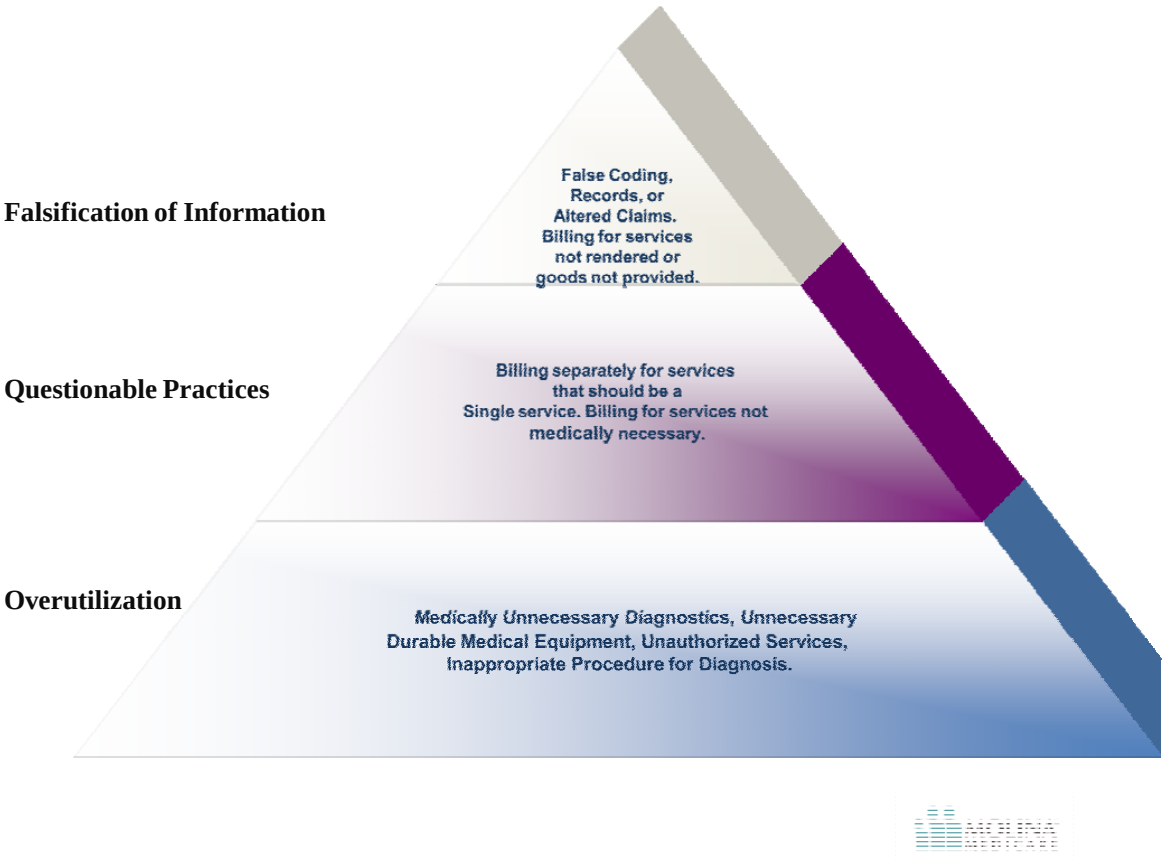
17. Questionable prescribing practices.

18. 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.

19. Underutilization, which means failing to provide services that are medically necessary.

20. 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.

21. Using the adjustment payment process to generate fraudulent payments.



G. Examples of Fraud, Waste, and Abuse by a Member

The types of questionable Member schemes investigated by Molina Healthcare 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.

H. Prepayment Fraud, Waste and Abuse Detection Activities

Through implementation of claims edits, Molina Healthcare's claims payment system is designed to audit claims concurrently, in order to detect and prevent paying claims that are inappropriate.

I. 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 Healthcare 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 Healthcare 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 Healthcare, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina Healthcare, in Molina Healthcare'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 Healthcare 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 Healthcare and without charge to Molina Healthcare. In the event Molina Healthcare identifies fraud, waste or abuse, Provider agrees to repay funds or Molina Healthcare may seek recoupment.

If a Molina Healthcare auditor is denied access to Provider's records, all of the claims for which Provider received payment from Molina Healthcare 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 Healthcare may offset such amounts against any amounts owed by Molina Healthcare to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina Healthcare) and without charge to Molina Healthcare. 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 Healthcare, Provider is required to allow Molina Healthcare 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.

J. Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste or abuse, you must notify Molina Healthcare's Compliance department **– see Section C above.** You have the right to report your concerns anonymously without fear of retaliation. Information reported to Compliance will remain confidential to the extent possible as allowed by law.

When reporting an issue, please provide as much information as possible. The more information provided, the better the chances the situation will be successfully reviewed and resolved. Information that should be reported includes:

- Allegation – A complete description of the allegation, including the type of fraud, waste, or abuse (e.g., balance billing, falsification of information, billing for services not rendered).
- Suspect's Identity – The names, including any aliases or alternative names, of individuals and/or entity involved in suspected fraud and/or abuse including address, telephone number, email address, Medicare and/or Medicaid ID number and any other identifying information.
- Dates of Occurrence – When did the fraud, waste, or abuse happen? Provide dates and times.

13. Credentialing and Recredentialing

The purpose of the Credentialing Program is to strive to assure that the Molina Healthcare network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina Healthcare to provide superior health care to the community.

The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer Providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with state and federal requirements and accreditation guidelines. In accordance with those standards, Molina Healthcare Members will not be referred and/or assigned to you until the credentialing process has been completed.

Criteria for Participation in the Molina Healthcare Network

Molina Healthcare has established criteria and the sources used to verify these criteria for the evaluation and selection of Providers for participation in the Molina Healthcare network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina Healthcare 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 Healthcare.

Molina Healthcare reserves the right to exercise discretion in applying any criteria and to exclude Providers who do not meet the criteria. Molina Healthcare may, after considering the recommendations of the Credentialing Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined that such waiver is necessary to meet the needs of Molina Healthcare and the community it serves. The refusal of Molina Healthcare 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 Healthcare 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 Healthcare network. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

1. Provider must practice, or plan to practice within ninety (90) calendar days, within the area served by Molina Healthcare.
2. All Providers, including ancillary Providers, (i.e. vision, pharmacy, etc.), will apply for enrollment in the Medicaid program. Providers are required to have an NPI or an Administrative Provider Identification Number (APIN).

3. Provider must complete and submit to Molina Healthcare a credentialing application. The application must be entirely complete. The Provider must sign and date that application attesting that their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. If Molina Healthcare or the Credentialing Committee requests any additional information or clarification the Provider must supply that information in the time-frame requested.
4. Provider must have a current, valid license to practice in their specialty in every state in which they will provide care for Molina Healthcare Members.
5. If applicable to the specialty, Provider must hold a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration. If a Provider has never had any disciplinary action taken related to his/her DEA or CDS and chooses not to have a DEA or CDS, the Provider may be considered for network participation if they submit a written prescription plan describing the process for allowing another Provider with a valid DEA or CDS certificate to write all prescriptions. If a Provider does not have a DEA because of disciplinary action including but not limited to being revoked or relinquished, the Provider is not eligible to participate in the Molina Healthcare network.
6. Providers will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore Providers must confine their practice to their credentialed area of practice when providing services to Molina Healthcare Members.
7. Providers must have graduated from an accredited school with a degree required to practice in their specialty.
8. Oral Surgeons and Physicians (MDs, DOs) must have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. Molina Healthcare only recognizes training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must have completed a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).
9. Board certification in the specialty in which the Provider is practicing is preferred but not required. Initial applicants who are not Board Certified may be considered for participation only if they have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. Molina Healthcare recognizes Board Certification only from the following Boards:
    a. American Board of Medical Specialties (ABMS)
    b. American Osteopathic Association (AOA)
    c. American Board of Podiatric Surgery (ABPS)
    d. American Board of Podiatric Medicine (ABPM)
    e. American Board of Oral and Maxillofacial Surgery
10. Providers who are not Board Certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Provider in the Molina Healthcare network. To be eligible, the Provider must have maintained a Primary Care practice in good standing for a minimum of the most recent five (5) years without any gaps in work history.

11. Provider must supply a minimum of five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If the Provider has practiced fewer than five (5)-years from the date of Credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse practitioner, clinical social worker) within the five (5)-years should be included. If Molina Healthcare determines there is a gap in work history exceeding six (6)-months, the Provider must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file. If Molina Healthcare determines there is a gap in work history that exceeds one (1)-year, the Provider must clarify the gap in writing.
12. Provider must supply a full history of malpractice and professional liability Claims and settlement history. Documentation of malpractice and professional liability Claims and settlement history is requested from the Provider on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
13. Provider must disclose a full history of all license actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Provider must also disclose any history of voluntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
14. At the time of initial application, the Provider must not have any pending or open investigations from any state or governmental professional disciplinary body.[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
15. Provider must disclose all Medicare and Medicaid sanctions. Provider must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
16. Provider must not be currently sanctioned, excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs.
17. Provider must have and maintain current professional malpractice liability coverage with limits that meet Molina Healthcare criteria. This coverage shall extend to Molina Healthcare Members and the Providers activities on Molina Healthcare's behalf.
18. Provider must disclose any inability to perform essential functions of a Provider in their area of practice with or without reasonable accommodation. If there is an affirmative

[3] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

response to the related disclosure questions on the application, a detailed response is required from the Provider.

19. Provider must disclose if they are currently using any illegal drugs/substances. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. If a Provider discloses any issues with substance abuse (e.g. drugs, alcohol) the Provider must provide evidence of either actively and successfully participating in a substance abuse monitoring program or successfully completing a program.
20. Provider must disclose if they have ever had any criminal convictions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
21. Provider must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
22. Provider must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Provider has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
23. Physicians (MD, DO), Primary Care Providers, Nurse Midwives, Oral Surgeons, Podiatrists and/or those Providers dictated by state Law, must have admitting privileges in their specialty. If a Provider chooses not to have admitting privileges, the Provider may be considered for network participation if they have a plan for hospital admission by using a Hospital Inpatient Team or having an arrangement with a credentialed Molina Healthcare participating Provider that has the ability to admit Molina Healthcare patients to a hospital. Providers practicing exclusively on a consultative basis are not required to have admitting hospital privileges. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Psychiatry, Sleep Medicine, Sports Medicine, Telemedicine, Urgent Care and Wound Management do not require admitting privileges.
24. Providers not able to practice independently according to state Law must have a practice plan with a supervising physician approved by the state licensing agency. The supervising physician must be contracted and credentialed with Molina Healthcare.
25. Providers currently listed on the Medicare Opt-Out Report may not participate in the Molina Healthcare network for any Medicare line of business.
26. If applicable to the specialty, Provider must have a plan for shared call coverage that includes twenty-four (24)-hours a day, seven (7) days per week and three-hundred-sixty-five (365) days per year. The covering Provider(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day. All Primary Care Providers must have twenty-four (24)-hour coverage. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Sleep Medicine, Telemedicine, Sports Medicine, Urgent Care and Wound Management are not required to have twenty-four (24)-hour coverage.
27. Molina Healthcare may determine, in its sole discretion, that a Provider is not eligible to apply for network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or

terminated from network participation by Molina Healthcare, who is currently in the Fair Hearing Process, or who is under investigation by Molina Healthcare. Molina Healthcare also may determine, in its sole discretion that a Provider cannot continue network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from network participation by Molina Healthcare. For purposes of this criteria, a company is "owned" by a Provider when the Provider has at least five percent (5%) financial interest in the company, through shares or other means.

28. Providers denied by the Credentialing Committee are not eligible to reapply until one (1) year after the date of denial by the Credentialing Committee. At the time of reapplication, Provider must meet all criteria for participation outlined above.
29. Providers terminated by the Credentialing Committee or terminated from the network for cause are not eligible to reapply until five (5) years after the date of termination. At the time of reapplication, Provider must meet all criteria for participation as outlined above.
30. Providers denied or terminated administratively are eligible to reapply for participation anytime as long as the Provider meets all criteria for participation above.

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 Healthcare 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 Healthcare 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 Healthcare 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 Credentialing Committee's review must be re-verified. The Credentialing Committee 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 Healthcare 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 Healthcare and the Provider remains in place, Molina Healthcare will recredential the Provider upon his or her return. Molina Healthcare will document the reason for

the delay in the Provider's file. At a minimum, Molina Healthcare 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 Healthcare will complete the recredentialing cycle. If either party terminates the contract and there is a break in service of more than thirty (30) calendar days, Molina Healthcare will initially credential the Provider before the Provider rejoins the network.

Providers Terminating with a Delegate and Contracting with Molina Healthcare Directly

Providers credentialed by a delegate who terminate their contract with the delegate and either have an existing contract with Molina Healthcare or wish to contract with Molina Healthcare directly must be credentialed by Molina Healthcare within six (6)-months of the Provider's termination with the delegate. If the Provider has a break in service more than thirty (30) calendar days, the Provider must be initially credentialed prior to reinstatement.

Credentialing Application

At the time of initial credentialing and recredentialing, the Provider must complete a credentialing application designed to provide Molina Healthcare 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. Pencils or erasable ink will not be an acceptable writing instrument for completing credentialing applications. Molina Healthcare may use another organization's application as long as it meets all the factors. Molina Healthcare will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. 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.

Inability to Perform Essential Functions and Illegal Drug Use

An inquiry regarding illegal drug use and inability to perform essential functions may vary. Providers may use language other than "drug" to attest they are not presently using illegal substances. Molina Healthcare may accept more general or extensive language to query Providers about impairments; language does not have to refer exclusively to the present, or only to illegal substances.

History of Actions Against Applicant

An application must contain the following information, unless State Law requires otherwise:

- History of loss of license;
- History of felony convictions and;
- History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a Provider has had privileges.
- History of Medicare and Medicaid Sanctions

Current Malpractice Coverage

The application form must include specific questions regarding the dates and amount of a Provider's current malpractice insurance. Molina Healthcare may obtain a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the application.

For Providers with federal tort coverage, the application need not contain the current amount of malpractice insurance coverage. Provider files that include a copy of the federal tort letter or an attestation from the Provider of federal tort coverage are acceptable.

Correctness and Completeness of the Application

Providers must attest that their application is complete and correct when they apply for credentialing and recredentialing. If a copy of an application from an entity external to Molina Healthcare is used, it must include an attestation to the correctness and completeness of the application. Molina Healthcare does not consider the associated attestation elements as present if the Provider did not attest to the application within the required time frame of one-hundred-eighty (180) days. If state regulations require Molina Healthcare to use a credentialing application that does not contain an attestation, Molina Healthcare must attach an addendum to the application for attestation.

Meeting Application Time Limits

If the Provider attestation exceeds one-hundred-eighty (180) days before the credentialing decision, the Provider must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the Provider to update the attestation.

The Process for Making Credentialing Decisions

All Providers requesting participation with Molina Healthcare must complete a credentialing application. To be eligible to submit an application, Providers must meet all the criteria outlined above in the section titled “Criteria for Participation in the Molina Healthcare Network”. Providers requesting initial credentialing may not provide care to Molina Healthcare Members until the credentialing process is complete and final decision is rendered.

Molina Healthcare recredentials its Providers at least every thirty-six (36) months. Approximately six (6) months prior to the recredentialing due date, the Providers application will be downloaded from CAQH (or a similar NCQA accepted online applications source), or a request will be sent to the Provider requesting completion of a recredentialing application.

During the initial and recredentialing application process, the Provider must:

- Submit a completed application within the requested timeframe
- Attest to the application within the last one-hundred-eighty (180) calendar days
- Provide Molina Healthcare adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina Healthcare network.

Once the application is received, Molina Healthcare will complete all the verifications as outlined in the Molina Healthcare Credentialing Program Policy. In order for the application to be deemed complete, the Provider must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina Healthcare network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by Molina Healthcare must be provided.

If the Provider does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina Healthcare will discontinue processing of the application. This will result in an administrative denial or administrative termination from the Molina Healthcare network. Providers who fail to provide proof of meeting the criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.

At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process each credentialing file is assigned a level based on established guidelines. Credentialing files assigned a Level 1 are considered clean credentialing files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a Level 2 are reviewed by the Molina Healthcare Credentialing Committee.

At each Credentialing Committee meeting, Provider credentials files assigned a Level 2 are reviewed by the Credentialing Committee. All of the issues are presented to the Credentialing Committee Members and then open discussion of the issues commences. After the discussion, the Credentialing Committee votes for a final recommendation. The Credentialing Committee can approve, deny, terminate, approve on watch status, place on corrective action or defer their decision pending additional information.

Process for Delegating Credentialing and Recredentialing

Molina Healthcare will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet Molina Healthcare's requirements for delegation. Molina Healthcare's Delegation Oversight Committee (DOC) must approve all delegation and subdelegation arrangements, and retains the right to limit or revoke any and all

delegated credentialing activities when a delegate fails to meet Molina Healthcare's requirements.

Molina Healthcare's Credentialing Committee retains the right to approve new Providers and Provider sites and terminate Providers, Providers and sites of care based on requirements in the Molina Healthcare Credentialing Policy.

To be delegated for credentialing, IPAs and Provider Groups must:

- Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass Molina Healthcare's credentialing delegation pre-assessment, which is based on NCQA credentialing standards and requirements for the Medicaid and Medicare programs, with a score of at least ninety percent (90%).
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina Healthcare at pre-assessment.
- Agree to Molina Healthcare's contract terms and conditions for credentialing delegates.
- Submit timely and complete reports to Molina Healthcare as described in policy and procedure.
- Comply with all applicable Federal and State Laws.
- If the IPA or Provider Group subdelegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA certified in all ten (10) areas of accreditation.

Non-Discriminatory Credentialing and Recredentialing

Molina Healthcare does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, 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 Healthcare 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 Healthcare 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 Healthcare 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 Credentialing Committee or Medical Director decision regarding their participation in the Molina Healthcare network. This notification is sent within two (2) 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.

Confidentiality and Immunity

Information regarding any Provider or Provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by Law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under this Policy and Procedure. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a "Representative" shall mean any individual authorized to preform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section "information" may be any written or oral disclosures including, but not limited to, a Provider's or Provider's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or Provider's provision of patient care services.

By providing patient care services at Molina Healthcare, a Provider:

1. Authorizes representatives of Molina Healthcare to solicit, provide, and act upon information bearing on the Provider's qualifications.
2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal Claims against any representative who acts in accordance with the provisions of this policy and procedure.
3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina Healthcare membership and the continuation of such membership, and to the exercise of clinical privileges or provision of patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal Law. To the fullest extent permitted by State or Federal Law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

1. Any type of application or reapplication received by the Provider;
2. Actions reducing, suspending, terminating or revoking a Provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
3. Hearing and appellate review;
4. Peer review and utilization and quality management activities;
5. Risk management activities and Claims review;
6. Potential or actual liability exposure issues;
7. Incident and/or investigative reports;
8. Claims review;

9. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
10. Any activities related to monitoring the quality, appropriateness or safety of health care services;
11. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
12. Any Molina Healthcare operations and actions relating to Provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a Provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a Provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the Provider, or if permitted or required by Law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant State and Federal Law, and are not a limitation thereof.

All Members (voting and non-voting) and guests of the Credentialing Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality annually. Members and guests of the Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at Molina Healthcare.

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by Law. Access to these documents are restricted to authorized staff, Credentialing Committee Members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of Molina Healthcare. Each person is given a unique user ID and password. It is the strict policy of Molina Healthcare that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three (3)-months.

Minutes, reports and files of Credentialing Committee meetings are stored in secure electronic folders or in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable Laws.

Copies of minutes and any other related Credentialing Committee meeting materials will not be allowed to be removed from meetings of peer review committees and Credentialing staff will shred extra sets of information from such meetings. Electronic data and/or information are

password protected and Molina Healthcare Staff is instructed not to divulge passwords to their co-workers.

Providers Rights during the Credentialing Process

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

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 Healthcare (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 Practitioner 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 Healthcare 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 Healthcare 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 Healthcare.
- 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 Kari Horseman, CPCS, Credentialing Director at PO Box 2470 Spokane WA 99210.

Upon receipt of notification from the Provider, Molina Healthcare will document receipt of the information in the Providers credentials file. Molina Healthcare will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be

made immediately to the Providers 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 Healthcare'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 denied.

Providers Right to be Informed of Application Status

Providers have a right, upon request, to be informed of the status of their application. Providers applying for initial participation are sent a letter when their application is received by Molina Healthcare and are notified of their right to be informed of the status of their application in this letter.

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

Credentialing Committee

Molina Healthcare designates a Credentialing Committee to make recommendations regarding credentialing decisions using a peer review process. Molina Healthcare works with the Credentialing Committee to strive to assure that network Providers are competent and qualified to provide continuous quality care to Molina Healthcare Members. A Provider may not provide care to Molina Healthcare Members until the credentialing process is complete and the final decision has been rendered.

The Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicant Providers and for making recommendations regarding their participation in the Molina Healthcare network. In addition, the Credentialing Committee reviews Credentialing Policies and Procedures annually and recommends revisions, additions and/or deletions to the policies and procedures. Composed of network Providers, the committee is responsible for performing peer review of medical information when requested by the Medical Director, and recommending actions based on peer review findings, if needed. The committees report to the Quality Improvement Committee (QIC).

Each Credentialing Committee Member shall be immune, to the fullest extent provided by law, from liability to an applicant or Provider for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

Committee Composition

The Medical Director chairs the Credentialing Committee and appoints all Credentialing Committee Members. Each Member is required to meet all of Molina Healthcare's credentialing criteria. Credentialing Committee Members must be current representatives of Molina Healthcare's Provider network. The Credentialing Committee representation includes at least five (5) Providers. These may include Providers from the following specialties:

- Family Medicine
- Internal Medicine
- Pediatrics
- OB/GYN
- Surgery

Additionally, surgical specialists and Internal Medicine specialists may participate on the committee as appropriate. Other ad hoc Providers may be invited to participate when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Behavioral Health Provider, Nurse Practitioners, Chiropractors) may be appointed by the chairs to screen applicants from their respective profession and make credentialing recommendations to the Credentialing Committee.

Committee Members Roles and Responsibilities

- Committee Members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.
- Review/approve credentialing program policy and related policies established by Molina Healthcare on an annual basis, or more often as deemed necessary.
- Review and consider each applicant's information based on criteria and compliance requirements. The Credentialing Committee votes to make final recommendations regarding applicant's participation in the Molina Healthcare network.
- Conduct ongoing monitoring of those Providers approved to be monitored on a "watch status".
- Access clinical peer input when discussing standards of care for a particular type of Provider when there is no committee member of that specialty.
- Ensure credentialing activities are conducted in accordance with Molina Healthcare's Credentialing Program.
- Review quality improvement findings as part of the recredentialing and the ongoing monitoring process.

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 Healthcare and its Subcontractors may not subcontract with an Excluded Provider/Person. Molina Healthcare and its Subcontractors shall terminate subcontracts immediately when Molina Healthcare and its Subcontractors become aware of such excluded Provider/person or when Molina Healthcare and its Subcontractors receive notice. Molina Healthcare 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 Healthcare and its Subcontractors are unable to certify any of the statements in this certification, Molina Healthcare and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions

Molina Healthcare monitors Provider sanctions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality is identified.

Medicare Opt-Out

Providers participating in Medicare must not be listed on the Medicare Opt-Out report. Molina Healthcare reviews the opt-out reports released from the appropriate Medicare financial intermediary showing all of the Providers who have chosen to Opt-Out of Medicare. These reports are reviewed within thirty (30) calendar days of their release. If a Provider opts-out of Medicare, that Provider may not accept Federal reimbursement for a period of two (2) years. These Provider contracts will be immediately terminated for the Molina Healthcare Medicare line of business.

Medicare and Medicaid Sanctions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. Within thirty (30) calendar days of its release, Molina Healthcare reviews the report and if any Molina Healthcare Provider is found with a sanction, the Provider's contract is terminated effective the same date the sanction was implemented.

Molina Healthcare also monitors every month for state Medicaid sanctions/exclusions/terminations through each state's specific Program Integrity Unit (or equivalent). If a Molina Healthcare Provider is found to be sanctioned/excluded/terminated from any state's Medicaid program, the Provider will be terminated in every state where they are contracted with Molina Healthcare and for every line of business.

Sanctions or Limitations on Licensure

Molina Healthcare monitors for sanctions or limitations against licensure between credentialing cycles for all network Providers. All sanction or limitation of license information discovered during the ongoing monitoring process will be maintained in the Provider credentialing file. All Providers with identified sanctions or limitations on license in the ongoing monitoring process will be immediately placed into the full credentialing process and will be recredentialed early. The Provider must provide all necessary information to complete the recredentialing process within the requested time-frames or the Provider will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a recommendation.

NPDB Continuous Query (Proactive Disclosure Service)

Molina Healthcare enrolls all network Providers with the National Practitioner Data Bank ("NPDB") Continuous Query service.

Once the Provider is enrolled in the Continuous Query Service, Molina Healthcare will receive instant notification of all new NPDB reports against the enrolled Providers. When a new report is received between recredentialing cycles, the Provider will be immediately placed into the full credentialing process and will be recredentialed early. The Provider must provide all necessary information to complete the recredentialing process within the requested time-frames or the Provider will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Member Complaints/Grievances

Each Molina Healthcare Health Plan has a process in place to investigate Provider-specific complaints from Members upon their receipt. Molina Healthcare evaluates both the specific complaint and the Provider's history of issues, if applicable. The history of complaints is evaluated for all Providers at least every six (6) months.

Adverse Events

Each Molina Healthcare Health Plan has a process in place for monitoring Provider adverse events at least every six (6) months. An adverse event is an injury that occurs while a Member is receiving health care services from a Provider. Molina Healthcare monitors for adverse events at least every six (6) months.

System for Award Management (SAM)

Molina Healthcare monitors the SAM once per month to ensure Providers have not been sanctioned. If a Molina Healthcare Provider is found with a sanction, the Provider's contract is terminated effective the same date the sanction was implemented.

Medicare Opt-Out

Provider's participating in Medicare must not be listed on the Medicare Opt-Out report. Molina Healthcare reviews the opt-out reports released from the appropriate Medicare financial intermediary showing all of the Providers who have chosen to Opt-Out of Medicare. These reports are reviewed within thirty (30) calendar days of their release. If a physician or other Provider opts-out of Medicare, that physician or other Provider may not accept Federal reimbursement for a period of two (2) years. These Provider contracts will be immediately terminated for the Molina Healthcare Medicare line of business.

Program Integrity (Disclosure of Ownership/Controlling Interest)

Medicaid Managed Care health plans are required to collect specific information from network Providers prior to contracting and during credentialing to ensure that it complies with federal regulations that require monitoring of Federal and State sanctions and exclusions databases. This monitoring ensures that any network Providers and the following details of any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against these sources, ensuring compliance with 42 CFR §455. The categorical details required and collected at all initial and recredentialing must be current and are as follows:

1. Detailed identifying information for any individual who has ownership or controlling interest in the individual/entity being contracted if that individual has a history of criminal activity related to Medicaid, Medicare, or Title XX services (see 42 CFR §455.106).
2. Detailed identifying information for all individuals who exercise operational or managerial control either directly or indirectly over daily operations and activities (see 42 CFR §455.101).
3. Detailed identifying information for all individuals or entities that have a 5% or more ownership or controlling interest in the individual/entity being contracted (see 42 CFR §455.104).

Office Site and Medical Record Keeping Practices Review

A review of office sites where you see Molina Healthcare Members may be required. This review may be scheduled as soon as the Credentialing Department receives your application. This may also include a review of your medical record keeping practices. A passing score is required to complete the application process. Your cooperation in working with the site review staff and implementing any corrective action plans will expedite a credentialing decision.

Office site and medical record keeping reviews may also be initiated if any Member complaints are received regarding the physical accessibility, physical appearance or adequacy of waiting room and examining room space.

Range of Actions, Notification to Authorities and Provider Appeal Rights

Molina Healthcare uses established criteria in the review of Providers' performance. All adverse actions taken by the Credentialing Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986.

Range of Actions Available

The Molina Healthcare Credentialing Committee can take one of the following actions against Providers who fail to meet credentialing standards or who fail to meet performance expectations pertaining to quality of patient care:

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a Provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

This applies to all Providers who are contracted by Molina Healthcare. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. If at any point a Provider fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of patient care the Credentialing Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the Provider may be given the opportunity to appeal this decision.

Criteria for Denial or Termination Decisions by the Credentialing Committee

The criteria used by the Credentialing Committee to make a decision to deny or terminate a Provider from the Molina Healthcare network include, but are not limited to, the following:

1. The Provider's professional license in any state has or has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
2. Provider has or has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the Provider's acts, omissions or conduct.
3. Provider has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any state or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the Provider to Molina Healthcare Members.
4. Provider has or has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their federal Drug Enforcement Agency (DEA) certificate or Controlled Substance Certification or Registration.
5. Provider has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the Provider has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the Provider has complied with all such conditions, limitations, or restrictions and is

receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the Provider's practice.

6. Provider has or has ever had sanctions of any nature taken by any Governmental Program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or agency.
7. Provider has or has ever had any denials, limitations, suspensions or terminations of participation of privileges by any health care institution, plan, facility or clinic.
8. Provider's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
9. Provider has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
10. Provider has or has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the Provider's professional conduct or the health, safety or welfare of Molina Healthcare Members.
11. Provider has or has ever engaged in acts which Molina Healthcare, in its sole discretion, deems inappropriate.
12. Provider has or has ever had a pattern of Member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina Healthcare Members.
13. Provider has not complied with Molina Healthcare's quality assurance program.
14. Provider is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
15. Provider has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Provider makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
17. Provider has ever rendered services outside the scope of their license.
18. Provider has or has ever had a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
19. Provider has or has ever failed to comply with the Molina Healthcare Medical Record Review Guidelines.
20. Provider has or has ever failed to comply with the Molina Healthcare Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring on a Committee Watch Status

Molina Healthcare uses the credentialing category "watch status" for Providers whose initial or continued participation is approved by the Credentialing Committee with follow-up to occur. The Credentialing Committee may approve a Provider to be monitored on watch status when there are unresolved issues or when the Credentialing Committee determines that the Provider needs to be monitored for any reason.

When a Provider is approved on watch status, the Credentialing Department conducts the follow-up according to the Credentialing Committee direction. Any unusual findings are reported

immediately to the Molina Healthcare Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Credentialing Committee meeting for review and recommendation.

Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, Molina Healthcare may work with the Provider to establish a formal corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

A corrective action plan is a written improvement plan, which may include, but is not limited to the following:

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected
- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six (6) months)

Within ten (10) calendar days of the Credentialing Committee's decision to place Provider on a corrective action plan, the Provider will be notified via a certified letter from the Medical Director. Such notification will outline:

- The reason for the corrective action
- The corrective action plan

If the corrective actions are resolved, the Provider's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing Committee may recommend that the Provider continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate Provider response to corrective action will be brought to the Credentialing Committee for review and decision.

Summary Suspension

In cases where the Credentialing Committee or the Medical Director becomes aware of circumstances that pose an immediate risk to patients, the Provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Medical Director shall promptly notify the Provider of the suspension by written notification sent via certified letter. Notification will include the following:

- A description of the action being taken.

- Effective date of the action.
- The reason(s) for the action and/or information being investigated.
- Information (if any) required from the Provider.
- The length of the suspension.
- The estimated timeline for determining whether or not to reinstate or terminate the Provider.
- Details regarding the Providers right to request a fair hearing within thirty (30) calendar days of receipt of the notice and their right to be represented by an attorney or another person of their choice (see Fair Hearing Plan policy).
- If the Provider does not request a fair hearing within the thirty (30) calendar days, they have waived their rights to a hearing.
- The action will be reported to the NPDB if the suspension is in place longer than thirty (30) calendar days.

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing Committee. The Credentialing Committee has the authority to implement corrective action, place conditions on the Provider's continued participation, discontinue the suspension or terminate the Provider.

Denial

After review of appropriate information, the Credentialing Committee may determine that the Provider should not be approved for participation in the Molina Healthcare network. The Credentialing Committee may then vote to deny the Provider.

The Provider will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of denial via certified mail, from the Medical Director, which includes the reason for the denial.

Termination

After review of appropriate information, the Credentialing Committee may determine that the Provider does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing Committee may then vote to terminate the Provider.

Terminations for Reasons Other Than Unprofessional Conduct or Quality of Care

If the termination is based on reasons other than unprofessional conduct or quality of care, the Provider will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of termination via certified mail, from the Medical Director, which includes the following:

1. A Description of the action being taken
2. Reason for termination

Terminations Based on Unprofessional Conduct or Quality of Care

If the termination is based on unprofessional conduct or quality of care, the Provider will be given the right to a fair hearing.

Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of Molina Healthcare's intent to terminate them from the network, via certified mail from the Medical Director, which includes the following:

- A Description of the action being taken.
- Reason for termination.
- Details regarding the Provider's right to request a fair hearing within thirty (30) calendar days of receipt of notice (see Fair Hearing Plan policy). The Fair Hearing Policy explains that Molina Healthcare will appoint a hearing officer and a panel of individuals to review the appeal.
- The Provider does not request a fair hearing within the thirty (30) calendar days, they have waived their rights to a hearing.
- The notice will include a copy of the Fair Hearing Plan Policy describing the process in detail.
- Provider's right to be represented by an attorney or another person of their choice.
- Obligations of the Provider regarding further care of Molina Healthcare Patients/Members.
- The action will be reported to the NPDB and the State Licensing Board.

Molina Healthcare will wait thirty (30) calendar days from the date the terminated Provider received the notice of termination. If the Provider requests a fair hearing within that required timeframe, Molina Healthcare will follow the Fair Hearing Plan Policy. Once the hearing process is completed, the Provider will receive written notification of the appeal decision which will contain specific reasons for the decision (see Fair Hearing Plan Policy). If the hearing committee's decision is to uphold the termination, the action will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below. If the hearing committee overturns the termination decision and the Provider remains in the Molina Healthcare network, the action will not be reportable to the State Licensing Board or to the NPDB.

If the Provider does not request a hearing within the thirty (30) calendar days, they have waived their rights to a hearing and the termination will become the final decision. A written notification of the final termination will be sent to the Provider and the termination will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below.

Reporting to Appropriate Authorities

Molina Healthcare will make reports to appropriate authorities as specified in the Molina Healthcare Fair Hearing Plan Policy when the Credentialing Committee takes or recommends certain Adverse Actions for a Provider based upon Unprofessional Conduct or quality of care. Adverse Actions include:

- Revocation, termination of, or expulsion from Molina Healthcare Provider status.

- Summary Suspension in effect or imposed for more than thirty (30) calendar days.
- Any other final action by Molina Healthcare that by its nature is reportable to the State Licensing Board and the NPDB.

Within fifteen (15) calendar days of the effective date of the final action, the Manager responsible for credentialing reports the action to the following authorities:
- All appropriate state licensing agencies
- National Practitioner Data Bank (NPDB)

A letter is then written to the appropriate state licensing boards describing the adverse action taken, the Provider it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate state licensing boards within twenty-four (24)-hours of receiving the final NPDB report. A copy of this letter is filed into the Provider's credentials file. The action is also reported to other applicable State entities as required.

Fair Hearing Plan Policy

Under State and Federal Law, certain procedural rights shall be granted to a Provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board and the National Practitioner Data Bank (NPDB).

Molina Healthcare, Inc., and its Affiliates ("Molina Healthcare"), will maintain and communicate the process providing procedural rights to Providers when a final action by Molina Healthcare will result in a report to the State Licensing Board and the NPDB.

A. Definitions

1. Adverse Action shall mean an action that entitles a Provider to a hearing, as set forth in Section B (l)-(3) below.

2. Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina Healthcare Affiliate state plan wherein the Provider is contracted.

3. Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.

4. Medical Director shall mean the Medical Director for the respective Molina Healthcare Affiliate state plan wherein the Provider is contracted.

5. Molina Healthcare Plan shall mean the respective Molina Healthcare Affiliate state plan wherein the Provider is contracted.

6. Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.

7. Peer Review Committee or Credentialing Committee shall mean a Molina Healthcare Plan committee or the designee of such a committee.

8. Plan President shall mean the Plan President for the respective Molina Healthcare Affiliate state plan wherein the Provider is contracted.

9. Provider shall mean physicians, dentists, and other health care Practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).

10. State shall mean the licensing board in the state in which the Provider practices.

11. State Licensing Board shall mean the state agency responsible for the licensure of Provider.

12. 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 Healthcare Plan.

B. Grounds for a Hearing

Grounds for a hearing exist whenever the Peer Review Committee or Credentialing Committee takes or recommends any of the following Adverse Actions for a Provider based upon Unprofessional Conduct:

1. Revocation, termination of, or expulsion from Molina Healthcare Provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board and the NPDB.
2. Suspension, reduction, limitation, or revocation of authority to provide care to Molina Healthcare Members when such suspension, reduction, limitation, or revocation is reportable to the State Licensing Board and the NPDB.
3. Any other final action by Molina Healthcare that by its nature is reportable to the State Licensing Board and the NPDB.

C. Notice of Action

If the Peer Review Committee and/or Credentialing Committee have recommended an Adverse Action, the Committee shall give written notice to the Provider by certified mail with return receipt requested. The notice shall:

1. State the reasons for the action;
2. State any Credentialing Policy provisions that have been violated;
3. Advise the Provider that he/she has the right to request a hearing on the proposed Adverse Action;
4. Advise the Provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective

Molina Healthcare Plan Medical Director by certified mail, return receipt requested, or personal delivery;

5. Advise the Provider that he/she has the right to be represented by an attorney or another person of their choice.
6. Advise the Provider that the request for a hearing ***must*** be accompanied by a check in the amount of $1,000.00 as a deposit for the administrative expenses of the hearing and specify that this amount will be refunded if the Adverse Action is overturned;
7. State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal Law; and
8. Provide a summary of the Provider's hearing rights or attach a copy of this Policy.

D. Request for a Hearing - Waiver

If the Provider does not request a hearing in writing to the Chief Medical Officer within thirty (30) days following receipt of the Notice of Action, the Provider shall be deemed to have accepted the action or recommendation of the Peer Review Committee and/or Credentialing Committee, and such action or recommendation shall be submitted to the Chief Medical Officer for final decision. In the event that a timely written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Peer Review Committee and/or Credentialing Committee shall provide the Provider with a Notice of Hearing and Statement of Charges consistent with this Policy.

A Provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing to which he or she might otherwise have been entitled. If the Provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action shall be forwarded to the Chief Medical Officer for final approval. In the event of a submittal to the Chief Medical Officer upon the Provider's waiver as set forth herein, the Peer Review Committee and/or Credentialing Committee may submit to the Chief Medical Officer additional information relevant to its recommended Adverse Action to be considered by the Chief Medical Officer in accepting or rejecting the recommended Adverse Action.

E. Appointment of a Hearing Committee

1. Composition of Hearing Committee

The Chief Medical Officer/Plan President shall select the individuals to serve on the Hearing Committee. The Hearing Committee shall consist of individuals who are not in direct economic competition with the subject Provider; who shall gain no direct financial benefit from the outcome of the hearing; and, who shall have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. General knowledge of the matter involved shall not preclude a physician from serving as a Member of the panel.

The panel shall consist of three or more Providers and shall include, whenever feasible, at least one individual practicing the same specialty as the affected Provider. In the event Providers are not available to sit as Hearing Committee members, physicians from the community may be substituted by the Medical Director.

2. Scope of Authority

The Hearing Committee shall have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.

3. Responsibilities

The Hearing Committee shall:
a. Evaluate evidence and testimony presented.
b. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.
c. Maintain the privacy of the hearing unless the Law provides to the contrary.

4. Vacancies

In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.

5. Disclosure and Challenge Procedures

Any person appointed to the Hearing Committee shall disclose to the Chief Medical Officer/Plan President any circumstance likely to affect impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives. The Hearing Officer may remove any person appointed to the Hearing Committee if the Hearing Officer believes that the person is unable to render an impartial decision.

F. Hearing Officer

1. Selection

The Chief Medical Officer and/or Plan President shall appoint a Hearing Officer, who may be an attorney. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

2. Scope of Authority

The Hearing Officer shall have the sole discretion and authority to:
a. Exclude any witness, other than a party or other essential person.

b. Determine the attendance of any person other than the parties and their counsel and representatives.
c. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative, and shall also grant such postponement when all of the parties agree thereto.

3. Responsibilities

The Hearing Officer shall:
a. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;
b. Ensure that proper decorum is maintained;
c. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;
d. Issue rulings pertaining to matters of Law, procedure and the admissibility of evidence;
e. Issue rulings on any objections or evidentiary matters;
f. Discretion to limit the amount of time;
g. Assure that each witness is sworn in by the court reporter;
h. May ask questions of the witnesses (but must remain neutral/impartial);
i. May meet in private with the panel members to discuss the conduct of the hearing;
j. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;
k. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and
l. Prepare the written report.

G. Time and Place of Hearing

Upon receipt of a Request for Hearing, the Chief Medical Officer and/or Plan President shall schedule and arrange for a hearing. The Chief Medical Officer and/or Plan President shall give notice to the affected Provider of the time, place and date of the hearing, as set forth below. The date of commencement of the hearing shall be not less than thirty (30) days from the date of the Notice of the Hearing, and not more than sixty (60) days from the date of receipt of the Request for Hearing. Notwithstanding the above timeframes, the parties may agree to extensions, or the Hearing Officer may grant an extension on a showing of good cause. If more than one meeting is required for a hearing, the Hearing Officer shall set the date, time, and location for additional meetings.

H. Notice of Hearing

The Notice of Hearing shall contain and provide the affected Provider with the following:
1. The date, time and location of the hearing.
2. The name of the Hearing Officer.
3. The names of the Hearing Committee Members.

4. A concise statement of the affected Provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.
5. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.
6. A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the Provider to prepare a defense, including all documentary evidence which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.

Except with regard to the disclosure of witnesses, as set forth above, the Notice of Hearing may be amended from time to time, but not later than the close of the case at the conclusion of the hearing by the Hearing Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

I. Pre-Hearing Procedures

1. The Provider shall have the following pre-hearing rights:
   a. To inspect and copy, at the Provider's expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and
   b. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the Provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.

2. The Hearing Committee shall have the following pre-hearing right:

To inspect and copy, at Molina Healthcare's expense, any documents or other evidence relevant to the charges which the Provider has in his or her possession or control as soon as practicable after receiving the hearing request.

3. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:
   a. Whether the information sought may be introduced to support or defend the charges;
   b. The exculpatory or inculpatory nature of the information sought, if any;
   c. The burden attendant upon the party in possession of the information sought if access is granted; and
   d. Any previous requests for access to information submitted or resisted by the parties.

4. The Provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

5. It shall be the duty of the Provider, the Peer Review Committee and/or Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

6. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.

7. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the Provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of State.

J. Conduct of Hearing

1. Rights of the Parties

Within reasonable limitations, and as long as these rights are exercised in an efficient and expeditious manner, both sides at the hearing may:

a. Call and examine witnesses for relevant testimony.
b. Introduce relevant exhibits or other documents.
c. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
d. Otherwise rebut evidence.
e. Have a record made of the proceedings.
f. Submit a written statement at the close of the hearing.
g. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

The Provider may be called by the Peer Review Committee and/or Credentialing Committee and examined as if under cross-examination.

2. Course of the Hearing

a. Each party may make an oral opening statement.

b. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.
c. The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.
d. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.
e. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.

3. Use of Exhibits

a. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.
b. A description of the exhibits in the order received shall be made a part of the record.

4. Witnesses

a. Witnesses for each party shall submit to questions or other examination.
b. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.
c. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.
d. The party producing such witnesses shall pay the expenses of their witnesses.

5. Rules for Hearing:

a. Attendance at Hearings

Only those persons having a direct interest in the hearing are entitled to attend the hearing. This means that the hearing will be closed except for the parties and their representatives. The only exception is when good cause is shown satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the hearing to have others present.

b. Communication with Hearing Committee

There shall be no direct communication between the parties and the Hearing Committee other than at the hearing, unless the parties and the Hearing Committee agree otherwise. Any other oral or written communication from the parties to the Hearing Committee shall be directed to the Hearing Officer for transmittal to the Hearing Committee.

c. Interpreter

Any party wishing to utilize an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

K. Close of the Hearing

At the conclusion of the hearing, the Hearing Officer shall dismiss all parties and participate in the deliberations of the Hearing Committee. The Hearing Committee shall render its final decision by a majority vote, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached to the Hearing Officer.

Within thirty (30) days of the conclusion of the deliberations, the Hearing Officer shall issue a written report including the following:

1. A summary of facts and circumstances giving rise to the hearing.
2. A description of the hearing, including:
    a. The panel members' names and specialties;
    b. The Hearing officer's name;
    c. The date of the hearing;
    d. The charges at issue; and
    e. An overview of witnesses heard and evidence.
3. The findings and recommendations of the Hearing Committee.
4. Any dissenting opinions desired to be expressed by the hearing panel members.

Final adjournment of the Hearing Committee shall occur when the Hearing Officer has mailed or otherwise delivered the written report.

L. Burden of Proof

In all hearings it shall be incumbent on the Peer Review Committee and/or Credentialing Committee taking or recommending an Adverse Action to come forward initially with evidence in support of its action or decision. Thereafter, the Provider who requested the hearing shall come forward with evidence in his/her support.

The burden of proof during a hearing shall be as follows:

The Peer Review Committee or Credentialing Committee taking or recommending the Adverse Action shall bear the burden of persuading the Hearing Committee that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means

within the range of alternatives reasonably available to the Peer Review Committee and/or Credentialing Committee taking or recommending Adverse Action under the circumstances and not necessarily that the action or recommendation is the only measure or the best measure that could have been taken or formulated.

M. Provider Failure to Appear or Proceed

Failure, without good cause, of the Provider to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

N. Record of the Hearing/Oath

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by Molina Healthcare, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer shall be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

O. Representation

Each party shall be entitled to representation by an attorney at Law, or other representative at the hearing, at their own expense, to represent their interests, present their case, offer materials in support thereof, examine witnesses, and/or respond to appropriate questions.

P. Postponements

The Hearing Officer, for good cause shown, may postpone any hearing upon the request of a party or the Hearing Committee.

Q. Notification of Finding

The Hearing Office shall serve a copy of the written report outlining the basis of the Hearing Committee's decision to the Medical Director, the Peer Review Committee and/or Credentialing Committee imposing the Adverse Action, and the affected Provider.

R. Final Decision

Upon receipt of the Hearing Committee's decision, the Chief Medical Officer/Plan President shall either adopt or reject the Hearing Committee's decision. The Chief Medical Officer/Plan President's action constitutes the final decision.

S. Reporting

In the event the Chief Medical Officer/Plan President adopts the proposed decision of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse

Action, Molina Healthcare will submit a report to the State Licensing Board and the NPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

Reports to the State Licensing Board and the NPDB for adverse actions must be submitted within fifteen (15) days from the date the adverse action was taken.

T. Exhaustion of Internal Remedies

If any of the above Adverse Actions are taken or recommended, the Provider must exhaust the remedies afforded by this Policy before resorting to legal action.

U. Confidentiality and Immunity

Information regarding any Provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by Law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under these Policies and Procedures. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a "Representative" shall mean any individual authorized to preform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section "information" may be any written or oral disclosures including, but not limited to, a Provider's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or Provider's provision of patient care services.

By providing patient care services at Molina Healthcare, a Provider:

1. Authorizes representatives of Molina Healthcare to solicit, provide, and act upon information bearing on the Provider's qualifications.
2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal claims against any representative who acts in accordance with the provisions of this policy and procedure.
3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina Healthcare membership and the continuation of such membership, and to the exercise of clinical privileges or provision of patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal Law. To the fullest extent permitted by State or Federal Law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

1. Any type of application or reapplication received by the Provider;

2. Actions reducing, suspending, terminating or revoking a Provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
3. Hearing and appellate review;
4. Peer review and utilization and quality management activities;
5. Risk management activities and Claims review;
6. Potential or actual liability exposure issues;
7. Incident and/or investigative reports;
8. Claims review;
9. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
10. Any activities related to monitoring the quality, appropriateness or safety of health care services;
11. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
12. Any Molina Healthcare operations and actions relating to Provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a Provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a Provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the Provider, or if permitted or required by Law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant state and federal Law, and are not a limitation thereof.

14. Member Grievances and Appeals

Molina Healthcare 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.

A. 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 Healthcare;
   - 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 Healthcare 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 Healthcare extends the time necessary or refuses to grant an organization determination or reconsideration Molina Healthcare 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 Healthcare Members have a right file a complaint regarding the care provided. Molina Healthcare must respond to all Quality of Care complaints in writing to the Member. Molina Healthcare 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 Healthcare 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 Healthcare Utilization Management Department handles organization determination. Organization Determination is discussed in Section 15. 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.

4. **Part-D Appeals – Please see Section 15 – Medicare Part D, Section A**

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

The definitions that follow will clarify terms used by Molina Healthcare for Member Healthcare appeals and grievances. Following the definitions is a brief discussion of Molina Healthcare 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 healthcare services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare 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 Healthcare Medicare 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 Healthcare, 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 Healthcare such as: waiting times, the demeanor of healthcare 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: Denial Notices	A written denial notice by Molina Healthcare 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 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 Healthcare 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 Healthcare's adverse reconsiderations of organization determinations.
Inquiry	Any oral or written request to Molina Healthcare, 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 Healthcare 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 Healthcare 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 Healthcare; ▪ Molina Healthcare'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 Healthcare to approve, furnish, arrange for, or provide payment for healthcare 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 healthcare 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 Healthcare, 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 Healthcare grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by Molina Healthcare meets professionally recognized standards of healthcare, including whether appropriate healthcare 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 Healthcare 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.

C. Important Information about Member Appeal Rights

For information about **Members' appeal rights, call the Molina Healthcare Medicare Member & Provider Contact Center (M&PCC) Monday through Sunday 8:00 a.m. to 8:00 p.m. toll free at (866) 553-9494, or 711 for persons with hearing impairments (TTY/TDD).**

Below is information for Molina Healthcare 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 Healthcare Medicare Member & Provider Contact Center (M&PCC).

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. **Fast Seventy-two (72) hour review** – You can ask for a fast 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 on a fast appeal no later than seventy-two (72) hours 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	**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 should mail or deliver your written appeal to Molina Healthcare Medicare at: **Molina Healthcare Medicare** **Attn: Grievance and Appeals** **P.O. Box 22816** **Long Beach, CA 90801-9977** **Hours of Operation:** Monday through Sunday 8:00 a.m. to 8:00 p.m. **To file an oral grievance call us toll free:** **(866) 553-9494**

benefits you. 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	**TTY/TDD toll free access number: 711** **Fax Number: (562) 499-0610** **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**

15. 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 Healthcare expedite a coverage determination or redetermination.

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

A. Appeals/Redeterminations

When a Member's request for a coverage determination is denied, Members may choose someone (including an attorney, Provider, or other authorized representative) 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 Healthcare 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 Healthcare 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 Healthcare'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 Healthcare's compliance with determinations to decisions that fully or partially reverse an original Molina Healthcare denial. The IRE is currently Maximums Federal Services, Inc.

B. 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 Healthcare is committed to providing access to medically necessary prescription drugs to Members of Molina Healthcare. If a drug is prescribed that is not on Molina Healthcare'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 Healthcare'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 Healthcare at (888) 665-1328 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 Healthcare 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 Healthcare will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Molina Healthcare network pharmacy and other plan rules are followed.

   Formularies may be different depending on the Molina Healthcare Plan and will change over time. Current formularies for all products may be downloaded from our Website at www.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 Healthcare Medicare per the Centers for Medicare & Medicaid Services; and
- Co-payments for Molina Healthcare Medicare may differ by state and plan.

2016 Drug Tier for Molina Healthcare of Florida, Inc.	2016 Options Plus (HMO SNP) Special Needs Plan*
Tier 1 – Preferred Generic Drugs	$0
Tier 2 – Non-preferred Generic Drugs	$0
Tier 3 – Preferred Brand Drugs	$0 – $7.40
Tier 4 – Non-preferred Brand Drugs	$0 – $7.40
Tier 5 – Specialty Drugs	$0 – $7.40

***Please note: At CMS's discretion, co-payments and/or benefit design may change at the beginning of the next contract year and each year thereafter.**

3. **Restrictions on Molina Healthcare's Medicare Drug Coverage**

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Molina Healthcare 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 Healthcare may not cover the drug;
- **Quantity Limits:** For certain drugs, Molina Healthcare limits the amount of the drug that it will cover;
- **Step Therapy:** In some cases, Molina Healthcare 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 Healthcare 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.

4. **Non-Covered Molina Healthcare Medicare 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;
- Agents used for symptomatic relief of cough or colds;
- Prescription vitamins and minerals, except those used for prenatal care and fluoride preparations;
- Non-prescription drugs, except those medications listed as part of Molina Healthcare'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 Healthcare Members with Medicaid coverage may have a limited selection of these excluded medications as part of its Medicaid coverage for Members assigned to Molina Healthcare Medicaid.

5. **There may be differences between the Medicare and Medicaid Formularies.** The Molina Healthcare 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 Healthcare Medicare Formulary Exception –** Molina Healthcare Medicare 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 Healthcare website www.MolinaHealthcare.com.

7. **Requesting a Molina Healthcare Medicare Formulary Redetermination (Appeal) –** The appeal process involves an adverse determination regarding Molina Healthcare Medicare 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 Healthcare Medicare 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 Healthcare 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 Healthcare 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 Healthcare will honor this request.
   - If a Member submits an appeal without Provider support, Molina Healthcare 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 Healthcare 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 Healthcare 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 (866) 553-9494**. Written appeals must be mailed or **faxed toll free (866) 290-1309.**

8. **Initiating a Part D Exception (Prior Authorization) Request –** Molina Healthcare 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 Healthcare 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 Healthcare receives the completed request.

   Molina Healthcare will request submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by: 1) Molina Healthcare Pharmacy Technician under the supervision of a pharmacist; 2) Molina Healthcare Pharmacist; or, 3) Chief Medical Officer (CMO) of Molina Healthcare. Review criteria will be made available at the request of the Member or his/her prescribing Provider. Molina Healthcare 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;
      - United States Pharmacopeia-Drug Information (or its successor publications); and
      - DRUGDEX Information System.

   b. Requests for off-label use of medications will need to be accompanied with excerpts from one (1) of the three (3) CMS-required compendia for consideration. The submitted excerpts must site a favorable recommendation.

   c. Depending upon the prescribed medication, Molina Healthcare 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 Healthcare. 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 Healthcare denies coverage of the prescribed medication, Molina Healthcare 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 Healthcare 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 Healthcare 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 Healthcare does not give the Member a written notification within the specified timeframe, Molina Healthcare 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 Healthcare'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 Healthcare 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 Healthcare 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 Healthcare 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 Healthcare to make a re-determination, Molina Healthcare will request the necessary information within twenty-four (24) hours of the initial request for an expedited re-determination. Molina Healthcare 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.

11. **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.

16. Web-Portal

Molina Healthcare Providers may register on the Web Portal to verify Member eligibility and benefits, submit or search for service request/authorizations, submit claims or view claims status and view other information that is helpful.

Enhanced Security – Online access is more secure than phone or fax so Providers are encouraged to communicate with Molina Healthcare online. The Provider registration process includes a how-to video that guides Providers on the Web-Portal registration process. Providers may add additional users to their accounts. The level of access to information can be better controlled online, further improving information security.

Claims Status and Submissions – In the Web Portal, Providers can submit claims, view claim status updates, and receive status change notifications. Claims Information is updated daily so Providers will know sooner if a claim is paid or denied. Messaging capabilities will automatically notify Providers of claims and service request/authorization status changes. Providers can also submit claims in batch, create claims templates, submit corrected claims and void claim submissions.

Service Request/Authorization Enhancements – Providers are able to apply templates to requests that they use frequently, to copy information from previous requests, and to attach documentation and clinical notes, reducing the time it takes to prepare and submit requests. Providers are also able to view service requests/authorizations for their patients/Molina Healthcare Members and will receive notifications when they create a service request/authorization to determine if a patient/Molina Healthcare Member previously received the service.

Member Eligibility – Providers can access their Member eligibility details – with a Quick View bar that summarizes the Member's eligibility at a glance. Additional Member details include Member HEDIS® missed services, benefit summary of covered services and access to Member handbooks.

Member Roster – The Web Portal offers a flexible Member Roster tool to help make Member management easier for Providers. The feature provides the ability to view an up-to-date Member list and customize Member searches with built-in filters. Providers can view various statuses for multiple Members – such as new Members, inpatients that are or will be in a hospital, and if any Member has missing services through HEDIS® alerts. This feature also acts as a hub to access other applications within the Web Portal such as Claims, Member Eligibility, and Service Request/Authorizations.

HEDIS® Scorecard – The Healthcare Effectiveness Data and Information Set (HEDIS®) Scorecard measures the performance of care and needed services conducted by a Provider. The HEDIS® data is specifically measured so that the scores can be compared amongst various health plans. This feature emphasizes the quality aspect to our Providers and Members. The HEDIS® Scorecard also allows HEDIS® submissions to be electronic and automated, making delivery of documentation to the Molina Healthcare HEDIS® and Quality Department quicker and more efficient.

17. Risk Adjustment Management Program

A. Background

Risk Adjustment is the process used by CMS to adjust the payment made to Medicare Advantage organizations based on the health status and demographics (age and gender) of the Member. Diagnosis data collected from encounter and claim data is submitted to CMS for risk adjustment purposes,

B. Medical Record Documentation

Medical records play a vital role in the risk adjustment process because: i) they are a valuable source of diagnosis data; (ii) they help determine the ICD-10 codes that should be used; and (iii) they ensure that diagnosis data submitted to CMS is accurate.

Therefore, medical records need to be accurate, through and complete. Therefore, medical records should:

- 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; and
- Contain the physician's signature and credentials.

Furthermore, complete and accurate documentation allows for more meaningful and complete data exchanges between Providers and Molina Healthcare to effectively manage the care of the Member because they will help:

- Identify potential problems/care management needs
- Match healthcare needs with the appropriate level of care
- Improve communication among the Member's healthcare team
- Improve the overall Member healthcare evaluation process
- Provide a clear and accurate picture of our Member's health status

C. 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 Healthcare was accurate for risk adjustment purposes. Therefore, all claims/encounters submitted to Molina Healthcare are subject to federal audit or auditing by Molina Healthcare. If Molina Healthcare is selected for a RADV audit, Provider will be required to submit medical records to validate the data previously submitted.

D. Contact Information

Title	Telephone
AVP, Risk Adjustment	(888) 562-5442, extension 115025

Title	Telephone
Director, Risk Adjustment Analytics	(888) 562-5442, extension 114633
Director, Risk Adjustment Operations	(888) 562-5442, extension 111207

18. Glossary of Terms

Term	Definition
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.
Advance Directive	A Member's written instructions, recognized under Law, relating to the provision of health care, when the Member is not competent to make a health care decision as determined under Law.
Affiliate	An entity owned or controlled by Health Plan or Molina Healthcare, Inc.
Agreement	Provider Services Agreement between Provider and Health Plan and all attachments, exhibits, addenda, amendments, and incorporated documents or materials.
Appeal	A complaint lodged by a Member if they disagree with certain kinds of decisions made by the health plan.
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.
Centers for Medicare & Medicaid Services (CMS)	The agency responsible for Medicare, and certain parts of Medicaid, CHIP, MMP, and the Health Insurance Marketplace.
Claim	A bill for Covered Services provided by Provider.
Claims Delegate	An entity that agreed to administer Claims payment for certain Covered Services on behalf of Health Plan, as defined in the contract between Health Plan and the entity.
Clean Claim	A Claim for Covered Services submitted on an industry standard form, which has no defect, impropriety, lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.
Coinsurance	The amount a Member pays for medical services after the deductible is paid. Coinsurance amounts are usually percentages of approved amounts.
Co-payment or Copay	The amount a Member pays for medical services such as a provider's visit or prescription.
Covered Services	Those health care services and supplies, including Emergency Services, provided to Members that are Medically Necessary and are benefits of a Member's Product.
Cultural Competency Plan	A plan that ensures Members receive Covered Services in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds, and limited English proficiency.
Date of Service	The date on which Provider provides Covered Services or, for inpatient services, the date the Member is discharged.
Deductible	The amount a Member pays for healthcare or prescriptions, before the health plan begins to pay.

Term	Definition
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.
Downstream Entity	Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between Health Plan (or applicant) and Provider. These written arrangements continue down to the level of the ultimate provider of both health and administrative services
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 healthcare 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	Covered inpatient and outpatient services furnished by a provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.
Encounter Data	All data captured during the course of a single health care encounter that specifies: (i) the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices, and equipment associated with a Member receiving services during the encounter; (ii) the identification of the Member receiving and the provider providing the health care services during the single encounter; and (iii) a unique and unduplicated identifier for the single encounter.
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.
Government Contracts	Those contracts between Health Plan and state and federal agencies for the arrangement of health care services for Government Programs.
Government Programs	Various government sponsored health products in which Health Plan participates.
Government Program Requirements	The requirements of governmental authorities for a Government Program, which includes, but is not limited to, the requirements set forth in the Government Contracts.
Grievance	A complaint about the way a Medicare health plan is giving care.

Term	Definition
Grievance Program	The procedures established by Health Plan to timely address Member and Provider complaints or grievances.
Health Plan	Molina Healthcare of Florida, Inc.
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.
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 healthcare providers, including hospitals, who contract with HMOs to provide services to the HMO Members, but usually also see non-HMO patients.
Law	All Federal and State statutes and regulations applicable to this Agreement.
Long-Term 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 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 long-term care is custodial care. Medicare does not pay for this type of care if this is the only care needed.
Medicaid	The joint Federal-State program provided for under Title XIX of the Social Security Act, as amended.
Medically Necessary or Medical Necessity	Health care services that a healthcare provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and (iv) not more costly than an alternative service, or site of services, at least as likely to produce equivalent results.

Term	Definition
Medicare (Original Medicare)	A pay-per-visit health plan that lets Members go to any provider, hospital, or other healthcare supplier who accepts Medicare and is accepting new Medicare patients. Members must pay the deductible. Medicare pays its share of the Medicare approved amount, and Members pay a share (co-insurance). In some cases Members may be charged more than the Medicare-approved amount. The Original Medicare Plan has two (2) parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
Medicare Plan	A plan offered by a private company that contracts with Medicare to provide Members with all Medicare Part A and Part B benefits. In most cases, Medicare Plans also offer Medicare prescription drug coverage.
Medicare Advantage (MA) Plan	A program in which private health plans provide Covered Services through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as "Medicare"). Medicare Advantage also includes Medicare Advantage Special Needs Plans ("MA-SNP").
Member	A person enrolled in a Product and who is eligible to receive Covered Services
Network	A group of doctors, hospitals, pharmacies, and other healthcare experts hired by a health plan to take care of its Members.
Overpayments	A payment Provider receives, which after applicable reconciliation, Provider is not entitled to receive pursuant to Laws, Government Program Requirements, or this Agreement.
Participating Provider	A healthcare facility or practitioner contracted with and, as applicable, credentialed by Health Plan or Health Plan's designee.
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).
Provider	The entity identified on the Signature Page of the Agreement and includes any person or entity performing Covered Services on behalf of Provider and for which: (i) an entity of the Provider bills under an owned tax identification number; and (ii), when applicable, such person or entity has been approved by Health Plan as a Participating Provider. Each entity or person shall be considered an "Individual Provider".
Provider Manual	Health Plan's provider manuals, policies, procedures, documents, educational materials, and, as applicable, Supplemental Materials, setting forth Health Plan's requirements and rules that Provider is required to follow.
Quality Improvement Program (QI Program)	The policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.
Risk Adjustment	Payment methodology designed to pay appropriate premiums for each

Term	Definition
	Molina Healthcare 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 Facility (SNF)	A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.
Skilled Nursing Facility Care	This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff and that, as a practical matter, can't be provided on an outpatient basis.
Special Needs Plan	A special type of plan that provides more focused healthcare for specific groups of people, such as those who have both Medicare and Medicaid, or those who reside in a nursing home.
State Children's Health Insurance Program ("SCHIP" or "CHIP")	The program established pursuant to Title XXI of the Social Security Act, as amended.
Subcontractor	An individual or organization, including Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement, including delegation activities. For the avoidance of doubt, a Subcontractor does not include Individual Providers.
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 (MRC). An MRC has TTY operators available to send and interpret TTY messages.
Urgently Needed Services	Care that Members get for a sudden illness or injury that needs medical care right away, but 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 the return home, the health plan must pay for urgently needed care.
Utilization Review and Management Program ("UM Program")	The policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including, but not limited to, under-utilization and over-utilization.
Waste	Healthcare spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use.

Term	Definition
	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.