

**2014 Provider Manual
Molina Healthcare of Ohio, Inc.
Molina Dual Options MyCare Ohio
(Medicare-Medicaid Plan)**

Thank you for your participation in the delivery of quality healthcare services to Molina Dual Options MyCare Ohio Plan 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 of Ohio Inc. Services Agreement. In the event of any conflict between this Manual and the Manual distributed with reference to Molina Medicaid or Molina Medicare Members, this Manual shall take precedence over matters concerning the management and care of Molina Dual Options Plan 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 Health Care.

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

The provider manual is reviewed, evaluated and updated as needed and at a minimum annually.

Dear Provider:

I would like to extend a personal welcome to Molina Healthcare of Ohio. Enclosed is your Molina Dual Options Plan Provider Manual, written specifically to address the requirements of delivering health care services to Molina Dual Options MyCare Ohio Plan 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 Dual Options MyCare Ohio Plan 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's Dual Options Plan members.

Sincerely,

Amy Schultz Clubbs
President
Molina Healthcare of Ohio, Inc.

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I. Introduction

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

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

A. Molina Dual Options (MMP)

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

Please contact the Member Services Department from **8:00 a.m. – 8:00 p.m. 7 days a week in local time zones toll free at (855) 665-4623** 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 Medicare-Medicaid website as they occur. All contracted providers will receive an updated Provider Manual annually, which will be made available at Molinahealthcare.com.

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

II. Background and Overview of Molina Healthcare, Inc. (Molina)

Molina, 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 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 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 became licensed as a Health Maintenance Organization (HMO) in California. Today, Molina serves over 1.8 million members in 10 states.

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's Mission, Vision and Core Values

- 1. Mission** – to promote health and provide health services to families and individuals who traditionally have faced barriers to quality health, have lower income and are covered by government programs.
- 2. Vision** – Molina is an innovative healthcare leader providing quality care and accessible services in an efficient and caring manner.
- 3. Core Values:**
 - We strive to be an exemplary organization;
 - We care about the people we serve and advocate on their behalf;
 - We provide quality service and remove barriers to health services;
 - We are healthcare innovators and embrace change quickly;
 - We respect each other and value ethical business practices; and
 - We are careful in the management of our financial resources and serve as prudent stewards of the public funds.

B. Significant Growth of Molina

Since 2001, Molina, 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 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 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'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 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. for specific centralized management, marketing, and administrative services.

E. Quality

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

F. Flexible Care Delivery Systems

Molina 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-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 has a thirty-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 as an option for 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.

III. Contact Information for Providers - Molina Dual Options Plan

Molina Dual Options Plan- Ohio

PO Box 349020

Columbus, OH 43234-9020

24 HOUR NURSE ADVICE LINE FOR MOLINA DUAL OPTIONS PLAN MEMBERS		
Services available in English and in Spanish.	English Telephone	(888) 275-8750
	Spanish Telephone	(866) 648-3537
	Hearing Impaired (TTY/TDD)	7-1-1
CLAIMS AND CLAIMS APPEALS		
Mailing Address: Molina Dual Options Claims PO Box 22712 Long Beach, CA 90801	Telephone	(855) 322-4079
Physical Address for overnight packages: Molina Healthcare of Ohio 3000 Corporate Exchange Drive Columbus, OH 43231		
COMPLIANCE/ANTI-FRAUD HOTLINE		
Confidential Compliance Official Molina Healthcare of Ohio P.O. Box 349020 Columbus, OH 43234-9020	Telephone	(866) 606-3889
	Fax	(888) 665-0860
	Email	corporatecompliance@molinahealthcare.com
CREDENTIALING		
Molina Dual Options Plan of Ohio Credentialing Department PO Box 349020	Telephone	(855) 665-4623
	Fax	(855) 266-5462

Columbus, OH 43234-9020		
QUALITY IMPROVEMENT		
Molina Dual Options Plan - Ohio Quality Improvement Department PO Box 349020 Columbus, OH 43234-9020	Telephone	(855) 665-4623
	Fax	(855) 266-5462
UTILIZATION MANAGEMENT, REFERRALS & AUTHORIZATION		
Molina Dual Options Plan - Ohio Utilization Management PO Box 349020 Columbus, OH 43234-9020	Telephone	(855) 322-4079
	Fax	(866) 449-6843
HEARING AND DENTAL		
Avesis Third Party Administrators 10324 S Dolfield Road Owings Mill, MD 21117	Telephone	Toll Free Phone (800) 327-4462
VISION		
March Vision Care 6701 Center Drive W Suite 790 Los Angeles, CA 90045	Telephone	Toll Free Phone (888) 493-4070
TRANSPORTATION		
Logisticare	Telephone	Toll Free 1-866-475-5423
	TTD/TTY	1-866-288-3133

IV. Eligibility and Enrollment in Molina Dual Options Plan a Medicare-Medicaid Program

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

- Age 18 and older at the time of enrollment;
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits;
- Eligible for full Medicaid;
- Individuals eligible for full Medicaid per the spousal impoverishment rule codified at section 1924 of the Social Security Act
- Reside in the applicable duals demonstration counties: Franklin, Delaware, Union, Madison, Pickaway, Clark, Greene, Montgomery, Warren, Butler, Hamilton and Clermont.
- Molina’s Dual Options Plan will accept all Members that meet the above criteria and elect Molina’s Dual Options Plan during appropriate enrollment periods.

B. Enrollment/Disenrollment Information

All members of Molina’s Dual Options Plan are full benefit dual eligible (e.g., they receive both Medicare and Medicaid). Centers for Medicare & Medicaid Services (CMS) rules state that these members may enroll or disenroll from Participating Plans and transfers between Participating Plans on a month-to-month basis any time during the year; and will be effective on the first day of the month following the request to do so.

C. Prospective and Existing Member Toll-Free Telephone Numbers

Existing Members may call our Member Services Department 8:00 a.m. to 8:00 p.m. 7 days a week in local time zones at (855) 665-4623. For TTY/TDD users call 711.

D. Effective Date of Coverage

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

E. Disenrollment

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

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

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

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

Molina's Dual Options Plan will refer the member to the Ohio Department of Medicaid (ODM) (or their designated vendor) to process disenrollment of members from the health plan only as allowed by CMS regulations. Molina's Dual Options Plan may request that a member be disenrolled under the following circumstances:

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

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

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

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

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

Provider and or members may contact our Member Services Department at (855) 665-4623 to discuss enrollment and disenrollment processes and options.

F. Member Identification Card Example – Medical Services

Molina Dual Options MyCare Ohio Medicaid

Front



Molina Dual Options MyCare Ohio Medicaid

Member Name:
THIS IS A REALLY LONG NAME OF A MEMBER 1

Member ID: 00000001	Health Plan ID: 80840	Medicaid ID: 00000001
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PCP Name: This is a really long PCP name to test for wrapping of the PCP name 1

PCP Phone: (001) 001-0001

RxBIN:	BIN1
RxPCN:	PCN1
RxGRP:	RxGroup1

Back

In Case of an Emergency: Call 911 or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your Primary Care Provider (PCP) or you may also contact our 24-Hour Nurse Advice Line at (888) 275-8750.

Member Services: (855) 687-7862 TTY 711 Monday - Friday 8 A.M.– 8 P.M.

24-Hour Behavioral Health Crisis: (888) 275-8750 TTY 711

24-Hour Care Management: (888) 275-8750 TTY 711

Website: www.MolinaHealthcare.com/duals

Send claims to : P.O. Box 22712, Long Beach, CA 90801; Payer ID #20149
(For pharmacist use only) **Pharmacy Tech:** (800) 364-6331

PRACTITIONERS/PROVIDERS/HOSPITALS: For prior authorization, eligibility, claims or benefits, visit the Molina Web Portal at www.MolinaHealthcare.com or call **(855) 322-4079**

Hospital Admissions: Authorization must be obtained by the hospital prior to all non-emergency admissions.

Molina Dual Options MyCare Ohio

Front

MyCareOhio
Connecting Medicare + Medicaid

Molina Dual Options MyCare Ohio (Medicare-Medicaid Plan)


Prescription Drug Coverage

Member Name:	THIS IS A REALLY LONG NAME OF A MEMBER 1	RxBIN: 004336
Member ID:		RxPCN: PCN1
Health Plan: 80840		RxGRP: RxGroup1
		RxID:
MMIS Number: 00000001		
PCP Name:	This is a really long PCP name to test for wrapping of the PCP name 1	
PCP Phone: (001) 001-0001		

115280-001

Back

In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Service:	(855) 665-4623 TTY/TDD 711 Monday - Friday, 8 a.m. - 8 p.m.
Eligibility Verification:	(855) 665-4623
Behavioral Health Crisis:	(888) 275-8750
Pharmacy Help Desk:	(866) 693-4620
Care Management:	(855) 665-4623
24-Hour Nurse Advice:	(888) 275-8750 TTY/TDD (866) 735-2929 711
Website:	www.Molinahealthcare.com/duals

Send Claims To: P.O. Box 22712, Long Beach, CA 90801
EDI Submission Payer ID 20149

G. Verifying Eligibility

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

MMP Eligibles and Cost-Share: Molina's Dual Options Plan allows only Members who are entitled to full Medicare and Medicaid benefits to enroll in Ohio plans.

To verify eligibility, providers may call Member Services at (855) 665-4623 or visit www.molinahealthcare.com

V. Quality Improvement

Molina Healthcare maintains a Quality Improvement (QI) Department to work with Members and providers in administering the Molina Medicare-Medicaid Quality Improvement Program. You can contact the Molina Healthcare QI Department toll free at (855) 665-4623

The address for mail requests is:

Molina Dual Options MyCare Ohio Plan
Quality Improvement Department
PO Box 349020
Columbus, OH 43234-9020

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

Molina Healthcare has established a QIPD 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 Medicare-Medicaid'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 site and medical record keeping and documentation practices.

A. **Patient Safety Program**

Molina Dual Options Plan's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Dual Options Plan members in collaboration with their primary care practitioners. 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 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 Practitioners (PCPs) every three (3) years that includes the following components:

- Medical record confidentiality and release of medical records including mental/behavioral healthcare 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; and
- 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 Dual Options Plan Quality Improvement Department toll free at (855) 665-4623. See also Chapter VII 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.

Category	Type of Care	Access Standard
Primary Care Provider (General Practitioners, Internist, Family Practitioners, Pediatricians)	Preventive/Routine Care	Within 6 weeks
	Urgent Care	By the end of the following work day
	Emergent Care	Triaged and treated immediately
	After Hours	Available by phone 24 hours a day, 7 days a week
OB/GYN	Pregnancy (initial visit)	Within 2 weeks
	Routine Visit	Within 6 weeks
Orthopedist	Routine Visit	Within 8 weeks
Otolaryngologist (ENT)	Routine Visit	Within 6 weeks
Dermatologist	Routine Visit	Within 8 weeks
Dental	Routine Visit	Within 6 weeks
Endocrinologist	Routine Visit	Within 8 weeks
Allergist	Routine Visit	Within 8 weeks
Neurologist	Routine Visit	Within 8 weeks
Behavioral Health	Routine Care	Within 10 business days
	Urgent Care	Within 48 hours
	Non-Life Threatening Emergency	Within 6 hours
All other Non-Primary Care	Routine Care	Within 8 weeks
All	Office Wait Time	Maximum of 30 minutes

1. **Appointment Access** - All providers who oversee the Member's health care are responsible for providing the following appointments to Molina Dual Options Plan Members in the timeframes noted:
2. **Office Wait Time** - For scheduled appointments, the wait time in offices should not exceed **30 thirty** 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 primary care 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 Dual Options Plan Member Services Department toll free at (855) 665-4623 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 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 Dual Options Plan's Member Services Department 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 appointment access standards is available from your local Molina Dual Options Plan QI Department toll free at (855) 665-4623.

B. 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 by fax and/or phone 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 www.caringinfo.org for forms available to download. Additionally, the Molina Dual Options Plan 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 Dual Options Plan 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 Dual Options Plan'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 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.

C. 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 Dual Options Plan 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 Diabetessm Program
- Healthy Living with Chronic Obstructive Pulmonary Disease
- Breathe with Easesm Asthma Program
- Smoking Cessation
- Motherhood Matters Program

- a. Program Eligibility Criteria and Referral Source** - Disease Management Programs are designed for active Molina Dual Options Plan 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 Dual Options Plan Member Services 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, ICD-9 and ICD-10 code;
 - Member Services welcome calls made by staff to new member households and incoming member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
 - 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.

- 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 the following:

- Coronary Artery Disease and/or Congestive Heart Failure
- Hypertension
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Asthma
- Cholesterol Management
- Depression
- Substance Abuse Treatment

Individual providers or Members may request copies by calling the Member Services Department toll free at (855) 665-4623.

- 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 Quality Improvement Committee.

- 4. Cultural and Linguistic Services** – Molina’s Dual Options Plan serves a diverse population of Members with specific cultural needs and preferences.

Title VI of the Civil Rights Act, *the Americans with Disabilities Act (ADA)* and *Section 504 of the Rehabilitation Act of 1973* and other regulatory / contract requirements ensures that limited English proficient (LEP) and *members who are deaf, hard of hearing or have speech or cognitive / intellectual impairments* have equal access to health care services through the provision of high quality cultural and linguistic services. Molina Healthcare provides a number of important cultural and linguistic services at no cost to assist members and Providers / Practitioners.

Members with Limited English Proficiency (LEP), Limited Reading Proficiency (LRP) or Limited Hearing or Sight

All eligible Members who are Limited English Proficient (LEP) are entitled to receive interpreter services. An LEP individual has a limited ability or inability to read, speak, or write English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations).

Molina Members are entitled to:

- Be provided with effective communications with medical providers as established by the
- Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Be given access to care managers trained to work with cognitively impaired individuals.
- Be notified by the medical provider that interpreter services are available at no cost to the client.
- Decide, with the medical provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
 - Interpreters must adhere to HHSC policies and procedures regarding confidentiality of client records.
 - Interpreters may, with client written consent, share information from the client's records only with appropriate medical professionals and agencies working on the client's behalf.
 - Interpreters must ensure that this shared information is similarly safeguarded.
- Have interpreters, if needed, during appointments with the Member's providers and when talking to their health plan.

Interpreters include people who can speak in the Member's native language, assist with a disability, or help the Member understand the information.

Arranging for Interpreter Services

Pursuant to Title VI of the Civil Rights Act of 1964, services provided for members with LEP, LRP or limited hearing or sight are the financial responsibility of the provider. Under no circumstances are Molina Healthcare members responsible for the cost of such services. Written Procedures are to be maintained by each office or facility regarding their process for obtaining such services.

When Molina Healthcare members need interpreter, translation, limited hearing and/or limited reading services for health care services the provider should:

- Verify the member's eligibility and medical benefits.
- Inform the members that interpreter, translation, limited hearing and/or limited reading services are available.

- Follow their written procedures for accessing such services which may include calling Language Line (800) 752-6096*, Voiance (866) 743-9010*, or Trusted Translations (877) 255-0717.*

*Molina Healthcare does not recommend nor endorse the above translation service providers. They are only referenced as examples.

- Molina Healthcare is available to assist providers with locating these services if needed.
 - Providers needing assistance finding onsite interpreter services may call Molina Healthcare Provider Services at 855-322-4079.
 - Providers needing assistance finding translation services may call Molina Healthcare Provider Services at 855-322-4079.
 - Providers with members who cannot hear or have limited hearing ability may use the Ohio Relay Service (TTY) TTY can be reached at 800-325-2223 or 711
 - Providers with members who cannot see may contact Molina Healthcare Provider Services at 855-322-4079 for documents in large print, Braille or audio version.
 - Providers with members with LRP may contact Molina Healthcare Provider Services at 855-322 4079. The Molina Healthcare Member Service Representative will verbally explain the information, up to and including reading the documentation to the members or offer the documents in audio version.

Providing Interpreter Services

Providers utilizing interpreter services shall document such services. Documentation of these services shall be kept in the member's medical record which may be audited by Molina Healthcare at any time.

Molina Healthcare expects Providers to inform Molina when providing interpreter services to its members. This information will be added to the member's record for future reference if needed. Providers may report this information to Molina Healthcare by calling Molina Healthcare Provider Services at 855-322-4079.

Nurse Advice Line

Molina Healthcare provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for members. The Nurse Advice Line provides access to 24 hour interpretive services. Members may call Molina Healthcare's Nurse Advice Line directly (English line (888) 275-8750) or (Spanish line at (866) 648-3537) or for assistance in other languages. *The Nurse Advice TTY is (866) 735-2929.* The Nurse Advice Line telephone numbers are also printed on membership cards.

Assistive Listening Devices

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

Documentation

As a contracted Molina Healthcare provider, your responsibilities for documenting member language services/needs are as follows:

- Record the member's language preference in a prominent location in the medical record. This information is provided to you on the electronic member lists that are sent to you each month by Molina Healthcare.
- All requests for interpreter services by members must be documented in the Member's medical record.
- Providers/Practitioners should document who provided the interpretation service. That information could be the name of their internal staff or someone from a commercial vendor.
- Offer your Molina Healthcare members interpreter services if they do not request them on their own.
- It is never permissible to ask a family member, friend or minor to interpret. If a member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after being notified of his or her right to have a qualified interpreter at no cost, document this in the member's medical record.
- All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done by utilizing interpretive services.

D. 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.

- 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 Dual Options Plan'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 Dual Options Plan'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 Provider Network. The survey results have helped establish improvement activities relating to Molina Dual Options Plan'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.

E. 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/ICD-9 and ICD-10 code sheet is available at for adults and children at:
[Preventative Health Guidelines](#)

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 Molinahealthcare.com/providers and click on Health Resources. There is a variety of resources, including:

- HEDIS[®] CPT/ICD-9 code sheet and ICD-10 code
- A current list of HEDIS[®] & CAHPS[®] Star Ratings measures

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

VI. The Health Insurance Portability and Accountability Act (HIPAA) – Medicare

A. Molina Medicare’s Commitment to Patient Privacy

Protecting the privacy of Members’ personal health information is a core responsibility that Molina Medicare takes very seriously. Molina Medicare is committed to complying with all Federal and state laws regarding the privacy and security of Members’ protected health information (PHI). Molina Medicare provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina Medicare uses and discloses their PHI and includes a summary of how Molina Medicare safeguards their PHI. A sample of Molina Medicare’s privacy notice is enclosed at the end of this section.

B. Provider Responsibilities

Providers play a key role in safeguarding PHI pertaining to Molina Medicare Members. Molina Medicare expects that its contracted providers will respect the privacy of Molina Medicare Members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

C. 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 including, without limitation, the following:

1. Federal Laws and Regulations

HIPAA; and Medicare and Medicaid laws.

- #### **2. State Medical Privacy Laws and Regulations** - Providers should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in the event state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

D. Uses and Disclosures of PHI

Member and patient PHI should be used or disclosed only 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. (See, Sections 164.506(c)(2) & (3) of the HIPAA Privacy Rule.) 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.” (See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule).
2. A covered entity may disclose PHI to another covered entity for the healthcare 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 healthcare operations activities:
 - Quality improvement;
 - Disease management;
 - Case management and care coordination;
 - Training Programs; or
 - Accreditation, licensing, and credentialing

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

E. 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.

F. Patient Rights

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

1. **Notice of Privacy Practices** – Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient’s privacy rights and the process the patients 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 healthcare providers 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.

G. HIPAA Security

HIPPA requires Providers to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person’s name and sometimes other parts of their identity - such as health insurance information - without the person’s knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina Medicare.

H. HIPAA Transactions and Code Sets

Molina strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina providers are encouraged to submit claims and other transactions using electronic formats. Certain electronic transactions are subject to HIPAA’s Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters;
- Member eligibility status inquiries and responses;
- Claims status inquiries and responses;
- Authorization requests and responses; and
- Remittance advices.

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina should refer to:

<http://www.molinahealthcare.com/medicaid/providers/tx/hipaa/Pages/home.aspx>

I. National Provider Identifier

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

J. Additional Requirements for Delegated Providers Entities

Providers that are delegated for claims, credentialing, utilization management, call center or any combination of these functions, are the “business associates” of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA’s Privacy and Security Rules.

Your Privacy

Dear Molina Member:

Your privacy is important to us. We respect and protect your privacy. Molina uses and shares your information to provide you with health benefits. Molina wants to let you know how your information is used or shared.

PHI stands for these words, *protected health information*. PHI means health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

- To provide for your treatment
- To pay for your health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To share PHI as required or permitted by law

When does Molina healthcare need your written authorization (approval) to use or share your PHI?

Molina Healthcare needs your written approval to use or share your PHI for purposes not listed above

What are your privacy rights?

- To look at your PHI

- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have given your PHI

How does Molina Healthcare protect your PHI?

Molina Healthcare uses many ways to protect PHI across our health plan. This includes PHI in written word, or electronic PHI. Below are some ways Molina protects PHI:

- Molina Healthcare has policies and rules to protect PHI
- Molina Healthcare limits who may see PHI. Only Molina Healthcare staff with a need to know PHI may use PHI
- Molina Healthcare staff is trained on how to protect and secure PHI
- Molina Healthcare staff must agree in writing to follow the rules and policies that protect and secure PHI
- Molina Healthcare secures PHI in our computers
- PHI in our computers is kept private by firewalls and passwords

What must Molina do by law?

- Keep your PHI private.
- Give you written information such as this on our duties and privacy practices about your PHI.
- Follow the terms of the enclosed Notice of Privacy Practices

What can you do if you feel your privacy rights have not been protected?

- Call or write Molina and complain.
- Complain to the Department of Health and Human Services.

We will not hold anything against you. Your action would not change your care in any way.

The above is only a summary. Please read the enclosed Notice of Privacy Practices. The Notice has more information about how we use and share your PHI.

We will be happy to answer your questions as a member of Molina Healthcare. Please call Molina Member Services at 855-665-4623, Monday-Sunday, 8:00AM to 8:00PM local time. TTY/TDD users, please call 1-800-346-4128.

NOTICE OF PRIVACY PRACTICES
MOLINA DUAL OPTIONS MYCARE OHIO

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Molina Healthcare of Ohio (“Molina” or “we”) uses and shares protected health information

about you to provide your health benefits as a Molina Medicare member. We use and share your information to carry out treatment, payment and health care operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private. We have policies in place to obey the law. The effective date of this notice is October 1, 2010.

PHI stands for these words, *protected health information*. PHI means health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

We use or share your PHI to provide you with healthcare benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment.

Molina may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes referrals between your doctors or other health care providers. For example, we may share information about your health condition with a specialist. This helps the specialist talk about your treatment with your doctor.

For Payment.

Molina may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, your condition, your treatment, and supplies given may be written on the bill. For example, we may let a doctor know that you have our benefits. We would also tell the doctor the amount of the bill that we would pay.

For Health Care Operations.

Molina may use or share PHI about you to run our health plan. For example, we may use information from your claim to let you know about a health program that could help you. We may also use or share your PHI to solve member concerns. Your PHI may also be used to see that claims are paid right.

Health care operations involve many daily business needs. It includes but is not limited to the following:

- Improving quality
- Actions in health programs to help members with certain conditions (such as asthma)
- Conducting or arranging for medical review
- Legal services, including fraud and abuse programs
- Actions to help us obey laws
- Address member needs, including solving complaints and grievances.

We will share your PHI with other companies (“business associates”) that perform different kinds of activities for our health plan.

We may also use your PHI to give you reminders about your appointments. We may use your PHI to give you information about other treatment, or other health-related benefits and services.

When can Molina use or share your PHI without getting written authorization (approval) from you?

In addition to treatment, payment and health care operations, the law allows or requires Molina to use and share your PHI for several other purposes, including the following:

Disclosure of your PHI to family members, other relatives and your close personal friends are allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either orally agreed to the disclosure or have been given an opportunity to object and have not objected.

Required by law.

We will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (HHS).

Public Health.

Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight.

Your PHI may be used or shared with government agencies. They may need your PHI for audits.

Research.

Your PHI may be used or shared for research in certain cases, when approved by a privacy or institutional review board.

Legal or Administrative Proceedings.

Your PHI may be used or shared for legal proceedings, such as in response to a court order.

Law Enforcement.

Your PHI may be used or shared with police to help find a suspect, witness or missing person.

Health and Safety.

PHI may be shared to prevent a serious threat to public health or safety.

Government Functions.

Your PHI may be shared with the government for special functions, such as national security activities.

Victims of Abuse, Neglect or Domestic Violence.

Your PHI may be shared with legal authorities if we believe that a person is a victim of abuse or neglect.

Workers Compensation.

Your PHI may be used or shared to obey Workers Compensation laws.

Other Disclosures.

PHI may be shared with funeral directors or coroners to help them to do their jobs.

When does Molina need your written authorization (approval) to use or share your PHI?

Molina needs your written approval to use or share your PHI for a purpose other than those listed in this notice. You may cancel a written approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

What are your health information rights?

You have the right to:

Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)

You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us to not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to fill out a form to make your request.

Request Confidential Communications of PHI

You may ask Molina to give you your PHI in a certain way or at a certain place to help keep your PHI private. We will follow reasonable requests, if you tell us how sharing all or a part of that PHI could put your life at risk. You will need to fill out a form to make your request.

Review and Copy Your PHI

You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions as a Molina member. You will need to fill out a form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases, we may deny the request.

Amend Your PHI

You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a member. You will need to fill out a form to make your request. You may file a letter disagreeing with us if we deny the request.

Receive an Accounting of PHI Disclosures (Sharing of your PHI)

You may ask that we give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:

- for treatment, payment or health care operations;
- to persons about their own PHI;

- sharing done with your authorization;
- incident to a use or disclosure otherwise permitted or required under law;
- as part of a limited data set for research or public health activities;
- PHI released in the interest of national security or for intelligence purposes;
- to correctional institutions having custody of an inmate; or
- shared prior to April 14, 2003

We will charge a reasonable fee for each list if you ask for this list more than once in a 12-month period. You must fill out a form to request a list of PHI disclosures.

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call Molina Member Services at 855-665-4623, 7 days a week from 8:00AM to 8:00PM local time. TTY/ TDD users, please call 711.

What can you do if your rights have not been protected?

You may complain to Molina and to the Department of Health and Human Services if you believe your privacy rights have been violated. We will not do anything against you for filing a complaint. Your care will not change in any way.

You may complain to us at the following:

By Phone: Molina Medicare Member Services 866-472-4584, Monday-Sunday, 8:00AM to 8:00PM local time. TTY/TDD users, please call 1-800-346-4128.

In Writing: Molina Healthcare of Ohio
Attention: Manager of Medicare Member Services
7050 Union Park Center, Suite 200
Midvale, UT 84047

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health & Human Services
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

What are the duties of Molina?

Molina is required to:

- Keep your PHI private.
- Give you written information such as this on our duties and privacy practices about your PHI.
- Follow the terms of this Notice

This Notice is Subject to Change

Molina reserves the right to change its information practices and terms of this notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, a new notice will be sent to you by US Mail.

Contact Information

If you have any questions, please contact the following office:

By Phone: Molina Medicare Member Services 866-472-4584, Monday-Sunday, 8:00AM to 8:00PM

local time. For TTY/TDD users call 711

In Writing: Molina Healthcare of Ohio
Attention: Medicare Member Services
7050 Union Park Center
Suite 200
Midvale, UT 84047

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name: 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:
2. Name of persons/organizations authorized to receive the protected health information:
3. Specific description of protected health information that may be used/disclosed:
4. The protected health information will be used/disclosed for the following purpose(s):
5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes____ No____
6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. Molina Healthcare may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.

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

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

10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that:

- a) action has been taken in reliance on this authorization; or
- b) if this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.

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

12. 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, if applicable

Relationship to Member or Personal 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

HIPAA (The Health Insurance Portability and Accountability Act) – Medicaid

A. 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). Molina Healthcare provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina Healthcare uses and discloses their PHI and includes a summary of how Molina Healthcare safeguards their PHI. A sample of Molina Healthcare’s privacy notice is enclosed at the end of this section.

B. Provider/Practitioner Responsibilities

Providers play a key role in safeguarding PHI pertaining to Molina Healthcare Members. Molina Healthcare expects that its contracted providers/practitioners will respect the privacy of Molina Healthcare Members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

C. Applicable Laws

Providers/Practitioners 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/practitioners must comply with. In general, most healthcare providers are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations

- HIPAA;
- Medicare and Medicaid laws;
- Applicable State Laws and Regulations

2. State Medical Privacy Laws and Regulations – Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the event state law is more stringent than HIPAA. Providers/Practitioners should consult with their own legal counsel to address their specific situation.

D. 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/Practitioner’s own TPO activities,

but also for the TPO of another covered entity¹. 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:

*See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.

1. A covered entity may disclose PHI to another covered entity or a 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."

*See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

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 healthcare operations activities:

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

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

E. 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.

F. Patient Rights

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

1. Notice of Privacy Practices – Providers/Practitioners 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/practitioner 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/practitioner restrict its uses and disclosures of PHI. The provider/practitioner is not required to agree to any such request for restrictions.

3. Requests for Confidential Communications – Patients may request that a health care

provider/practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners 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/Practitioner’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/practitioner 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/practitioner 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/practitioner 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.

G. HIPAA Security

HIPAA requires Providers/Practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers/Practitioners should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential. In addition, medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person’s name and sometimes other parts of their identity - such as health insurance information - without the person’s knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers/Practitioners should be aware of this growing problem and report any suspected fraud to Molina Healthcare.

H. HIPAA Transactions and Code Sets

Molina Healthcare strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare providers/practitioners are encouraged to submit claims and other transactions to Molina Healthcare using electronic formats. Certain electronic transactions are subject to HIPAA’s Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters;
- Member eligibility status inquiries and responses;
- Claims status inquiries and responses;
- Authorization requests and responses;
- Remittance advices.

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to: Molina Healthcare’s website at molinahealthcare.com for additional information. Click on the tab titled “Providers”, select a

state, click the tab titled “HIPAA” and then click on the tab titled “TCS Readiness”.

I. National Provider Identifier

Providers/Practitioners must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The provider/practitioner must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the provider/practitioner. The provider/practitioner 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/Practitioners must use its NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Healthcare.

J. Additional Requirements for Delegated Providers/Practitioners

Providers/Practitioners 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/Practitioners must agree to various contractual provisions required under HIPAA’s Privacy and Security Rules.

Your Privacy

Dear Molina Healthcare Member,

Your privacy is important to us. We respect and protect your privacy. Molina uses and shares your information to provide you with health benefits. Molina wants to let you know how your information is used or shared.

PHI stands for these words, *protected health information*. PHI means health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

- To provide for your treatment
- To pay for your health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To share PHI as required or permitted by law

When does Molina Healthcare need your written authorization (approval) to use or share your PHI?

- Molina Healthcare needs your written approval to use or share your PHI for purposes not listed above.

What are your privacy rights?

- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have given your PHI

How does Molina Healthcare protect your PHI?

Molina Healthcare uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word or PHI in a computer. *Below are some ways Molina protects PHI:*

- Molina Healthcare has policies and rules to protect PHI.
- Molina Healthcare limits who may see PHI. Only Molina Healthcare staff with a need to know PHI may use and share PHI.
- Molina Healthcare staff is trained on how to protect and secure PHI.
- Molina Healthcare staff must agree in writing to follow the rules and policies that protect and secure PHI.
- Molina Healthcare secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

What must Molina do by law?

- Keep your PHI private.
- Give you written information, such as this on our duties and privacy practices about your PHI.
- Follow the terms of our Notice of Privacy Practices

What can you do if you feel your privacy rights have not been protected?

- Call or write Molina Healthcare and complain.
- Complain to the Department of Health and Human Services.

We will not hold anything against you. Your action would not change your care in any way.

The above is only a summary. Please read the full Notice of Privacy Practices. The Notice has more information about how we use and share your PHI.

You may call our Member Services Department toll free **1-855-665-4623**. Hearing impaired call TTY/Ohio Relay Service **711**.

Notice of Privacy Practices Molina Healthcare of Ohio

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Molina Healthcare of Ohio (“Molina” or “we”) uses and shares protected health information about you to provide your health benefits. We use and share your information to carry out treatment, payment and health care operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private. We have policies in place to obey the law. The effective date of this notice is May 1, 2008.

PHI stands for these words, protected health information. PHI means health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

We use or share your PHI to provide you with health care benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment.

Molina may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes referrals between your providers or other health care providers. For example, we may share information about your health condition with a specialist. This helps the specialist talk about your treatment with your provider.

For Payment.

Molina may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, your condition, your treatment, and supplies given may be written on the bill. For example, we may let a provider know that you have our benefits. We would also tell the provider the amount of the bill that we would pay.

For Health Care Operations.

Molina may use or share PHI about you to run our health plan. For example, we may use information from your claim to let you know about a health program that could help you. We may also use or share your PHI to solve member concerns. Your PHI may also be used to see that claims are paid right. Health care operations involve many daily business needs. It includes but is not limited to, the following:

- Improving quality
- Actions in health programs to help members with certain conditions (such as asthma)
- Conducting or arranging for medical review
- Legal services, including fraud and abuse programs
- Actions to help us obey laws
- Address member needs, including solving complaints and grievances

We will share your PHI with other companies (“business associates”) that perform different kinds of activities for our health plan. We may also use your PHI to give you reminders about your appointments. We may use your PHI to give you information about other treatments, or other health-related benefits and services.

When can Molina use or share your PHI without getting written authorization (approval) from you?

In addition to treatment, payment and health care operations, the law allows or requires Molina to use and share your PHI for several other purposes including the following: Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either orally agreed to the disclosure or have been given an opportunity to object and have not objected.

Required by law.

We will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (HHS).

Public Health.

Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight.

Your PHI may be used or shared with government agencies. They may need your PHI for audits.

Research

Your PHI may be used or shared for research in certain cases, when approved by a privacy or institutional review board.

Legal or Administrative Proceedings

Your PHI may be used or shared for legal proceedings, such as in response to a court order.

Law Enforcement

Your PHI may be used or shared with police to help find a suspect, witness or missing person.

Health and Safety

PHI may be shared to prevent a serious threat to public health or safety.

Government Functions

Your PHI may be shared with the government for special functions, such as national security activities.

Victims of Abuse, Neglect or Domestic Violence

Your PHI may be shared with legal authorities if we believe that a person is a victim of abuse or neglect.

Workers Compensation

Your PHI may be used or shared to obey Workers Compensation laws.

Other Disclosures

PHI may be shared with funeral directors or coroners to help them do their jobs.

When does Molina need your written authorization (approval) to use or share your PHI?

Molina needs your written approval to use or share your PHI for a purpose other than those listed in this notice. You may cancel a written approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

What are your health information rights?

You have the right to:

Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)

You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us to not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to fill out a form to make your request.

Request Confidential Communications of PHI

You may ask Molina to give you your PHI in a certain way or at a certain place to help keep your PHI private. We will follow reasonable requests, if you tell us how sharing all or a part of that PHI could put your life at risk. You will need to fill out a form to make your request.

Review and Copy Your PHI

You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions as a Molina member. You will need to fill out a form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases we may deny the request.

Amend Your PHI

You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a member. You will need to fill out a form to make your request. You may file a letter disagreeing with us if we deny the request.

Receive an Accounting of PHI Disclosures (Sharing of your PHI)

You may ask that we give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:

- for treatment, payment or health care operations;
- to persons about their own PHI;
- sharing done with your authorization,
- incident to a use or disclosure otherwise permitted or required under applicable law;
- as part of a limited data set for research or public health activities;
- PHI released in the interest of national security or for intelligence purposes; to correctional institutions having custody of an inmate; or
- shared prior to April 14, 2003

We will charge a reasonable fee for each list if you ask for this list more than once in a 12-month period. You must fill out a form to request a list of PHI disclosures. You may make any of the requests listed above, or may get a paper copy of this Notice. Please call our Molina Healthcare of Ohio Member Services at 1-855-665-4623, TTY 711.

What can you do if your rights have not been protected?

You may complain to Molina and to the Department of Health and Human Services if you believe your privacy rights have been violated. We will not do anything against you for filing a complaint. Your care will not change in any way.

You may complain to us at:

Member Services Department
Molina Healthcare of Ohio, Inc.
P.O. Box 349020
Columbus, OH 43234-9020

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Office of Civil Rights
U.S. Department of Health & Human Services
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

What are the duties of Molina?

Molina is required to:

- Keep your PHI private
- Give you written information such as this on our duties and privacy practices about your PHI
- Follow the terms of this Notice

This Notice is Subject to Change

Molina reserves the right to change its information practices and terms of this notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, a new notice will be sent to you by US Mail.

Contact Information

If you have any questions, please contact the following office:

Member Services Department
Molina Healthcare of Ohio, Inc.
P.O. Box 349020
Columbus, OH 43234-9020
Toll Free:
1-855-665-4623
TTY 711

VII. Health Care Services (HCS) Program

This Molina Provider Manual contains excerpts from the Molina Health Care Services Program Description (HCSPD). For a complete copy of your state's Molina Medicare-Medicaid HCSPD you can access the Molina Dual Options MyCare Ohio Plan website at: www.MolinaHealthcare.com/Duals or contact Provider Services to request a written copy.

I. Introduction

Molina Healthcare, Inc. has significant nationwide experience providing care management services to Medicare Advantage, D-SNP, Dual Option, Medicaid and Health Insurance Marketplace members using processes designed to address a broad spectrum of disabilities and chronic conditions that require the coordination and provision of a wide array of health care services. To ensure that members receive high quality care, Molina¹ uses an integrated care management approach based on empirically validated best practices that have demonstrated positive results in numerous Molina managed care markets. Research and experience show that a higher-touch, member-centric care environment for at-risk members supports better health outcomes and reduces the need for institutional care.

Molina's Health Care Services (HCS) program is adaptable across state plans. Depending on the terms of specific Medicare Advantage, D-SNP, Dual Option, Medicaid and Health Insurance Marketplace contracts, certain services that are a part of the integrated model, such as behavioral health or long-term care, may be carved out. In other States, these services may be covered by the managed care plan.

Molina strives for full integration of physical health, behavioral health, long-term services and support (LTSS); and social support services to eliminate fragmentation of care and provide a single, individualized plan of care for members. The HCS program consists of four programmatic levels: Level 1 – Health Management for low-risk members; Level 2 – Case Management for medium-risk members; Level 3– Complex Case Management for high-risk members; and Level 4– Complex Case Management for eminent-risk members. Running concurrently with these four levels are the Care Access and Monitoring process, which ensures appropriate and effective utilization of services, and the Molina Transitions Program, which ensures members receive the support they need when moving from one care setting to another. Mental health, chemical dependency, and long-term care are integrated throughout all aspects of the HCS program. Through continuous process and technology improvements, Molina streamlines interactions between all Care Management teams to promote highly effective collaborations that result in optimized member care.

¹ The term "Molina" encompasses the parent organization, Molina Healthcare, Inc. and its subsidiary state health plans.

The Molina HCS Program is committed to comprehensive health care management for Special Needs Plan (SNP) members, traditional Medicare Advantage, D-SNP, Dual Option, Medicaid and Health Insurance Marketplace members. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service.

Molina works in partnership with members and practitioners to promote a seamless delivery of health care services and to coordinate services between the Medicare Advantage, D-SNP, Dual Option, Medicaid and Health Insurance Marketplace benefit when available. Molina-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.

A. Purpose

Molina has identified a new title for its Utilization Management program – Care Access and Monitoring – to reflect the important role this process plays in Molina’s new HCS program. Molina’s Care Access and Monitoring program ensures that care is medically necessary and demonstrates an appropriate use of resources based on the levels of care needed for a member. This program promotes the provision of quality, cost-effective and medically appropriate services that are offered across a continuum of care, integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes as necessary and is designed to influence member’s care by:

- Managing available benefits effectively and efficiently while ensuring quality care is provided;
 - Evaluating the necessity and efficiency of health care services across the continuum of care;
 - Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization;
 - Implementing comprehensive processes to monitor and control the utilization of health care resources;
 - Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness; and
 - Reviewing processes to ensure care is safe and accessible;
-
- Ensuring that qualified health care professionals perform all components of the UM / CM processes;

- Ensuring that UM decision tools are appropriately applied in determining medical necessity decision.

B. Scope

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

Eligibility and Oversight	Resource Management	Quality Management
Eligibility verification	Prior Authorization and Referral Management	Satisfaction evaluation of the Care Access and Monitoring program using member and practitioner input
Benefit administration and interpretation	Pre-admission, Admission and Concurrent Review	Utilization data analysis
Ensuring authorized care correlates to member’s medical necessity need(s) & benefit plan	Retrospective Review	Monitor for possible over- or under-utilization of clinical resources
Verifying current Physician/hospital contract status	Discharge Planning	Quality oversight including inter-rater reliability and productivity monitoring
Delegation oversight	Staff education on consistent application of UM functions	Monitor for adherence to CMS, NCQA, state and health plan UM standards

II. HCS Goals, Objectives and Functions

A. Program Goals

The goals of the Molina HCS Program are to:

- Achieve effective high quality outcomes by ensuring that medically necessary care is delivered in an appropriate setting at the time such service is needed by the member;
- Ensure the provision of effective and efficient utilization of services;
- Monitor the utilization practice patterns of participating physicians, hospitals and ancillary practitioners to identify over- or under- utilization;
- Identify and assess appropriate members for care management through health risk assessments, early identification of high or low service utilization and high cost, catastrophic, chronic or long term diseases;

- Facilitate the members transition from one level of care to another;
- Promote health care in accordance with local, state and national guidelines and standards;
- Identify events and patterns of care in which outcomes may be improved through efficiencies in utilization management (UM) and case management (CM) activities, and to implement actions that improve performance;
- Ensure timely responses to member and provider appeals;
- Continually seek to improve member and provider satisfaction with health care and utilization processes.

Communication and Availability to Members and Practitioners:

Molina HCS staff is accessible through a toll-free number (855) 322-4079 during normal business hours, Monday through Friday (except for Holidays) from 8:00 AM to 6:00 PM for information and authorization of care. When initiating, receiving or returning calls the UM staff will identify the organization, their name and title.

Molina's Nurse Advice Line is available to members and providers 24 hours a day, seven days a week. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters.

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

IV. Levels of Administrative and Clinical Review

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

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

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

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

The Organization Determination / Authorization requirements, timelines and procedures are published in the Provider Manual and available on the Molina Provider Web Site. In addition Molina's provider training includes information on the UM processes and Organization Determination / Authorization requirements.

A. Initial Administrative Review

Coordinators conduct initial administrative type reviews. They ensure that the information required to process a clinical review is requested and obtained. They verify member eligibility and status of the requested provider's participation with Molina.

The qualification of Coordinators includes a high school education and experience in the medical field, preferably in managed care positions.

Coordinators work with requesting providers to enter necessary information into the UM/CM information system (QNXT and MAPD). They monitor processing times for requests and assure that review requests are completed within established time frames.

Coordinators can approve requests for selected services, according to specified auto approval lists developed and approved by the HCS UM Director and Medical Directors. If a request is not on these lists, it is sent for clinical review, as described below.

B. Initial Clinical Review

Clinical Staff conduct the initial clinical review of health care service requests against medical appropriateness criteria. RNs, LPNs/LVNs, or other health professionals complete this initial review.

Qualifications include:

- Current State licensure if applicable;
- Adequate training to utilize medical appropriateness criteria and applicable review standards or medical policy;
- Clinically supported by a licensed physician or clinical peer.

UM Clinical Staff can approve requests that meet medical appropriateness criteria. If a request does not meet criteria, the request is reviewed by a Medical Director.

C. Health Professional Review

Medical Directors conduct clinical review of services that do not meet initial clinical review appropriateness criteria. The Medical Director or Pharmacy Director reviews

requests for medical necessity on all medication that does not meet initial review criteria. In addition, some services have a specific requirement for Organization Determination/Authorizations by a health professional, as noted by medical policy.

Qualifications include:

- Current non-restricted license to practice medicine and free of any sanctions from Medicaid or Medicare;
- Adequate training to utilize medical appropriateness criteria and other applicable review standards or medical policy;
- Ability to review cases for which a clinical decision cannot be made by the first level reviewer;
- Reasonable availability, i.e. within one business day, to discuss clinical determinations with the attending or ordering physician.

D. Specialist Clinical Review

Consultations and appeal reviews may require additional clinical review by appropriately credentialed specialists. Specialist reviewers should be trained in the same or similar specialty to the requesting practitioner. Qualifications include:

- Current non-restricted license to practice medicine or related health profession and free of any sanctions from Medicaid or Medicare;
- Board certification in the same or similar specialty that usually manages the medical condition, procedure or treatment under review;
- Familiar with appropriate care of patients similar to the member involved in the review;
- Oriented to the principles and procedures of the HCS Program, the medical appropriateness criteria and other standards or medical policy.

Review Criteria

Molina utilizes standardized nationally recognized review criteria that are based on sound scientific medical evidence for making decisions concerning medical necessity and appropriateness of services. The appropriate use of criteria is incorporated into all phases of the utilization decision making process by licensed staff and Medical Directors. The criteria sources used are one or more of the following:

- CMS Medicare Coverage Guidelines, Local and National Coverage Determinations, Medicare Benefit Policy Manual;
- Medicaid Coverage Guidelines;
- Corporate Guidance Documents addressing new or existing technology;
- McKesson InterQual® Criteria/Thomson's Length of Stay Guidelines by Diagnosis and DRG;
- Hayes Medical Technology Directory;

- Apollo Managed Care Managing Physical/Occupational Therapy and Rehabilitation Care Manual;
- Algorithms and guidelines from recognized professional societies;
- Advice from authoritative review articles and textbooks.
- State-mandated long term care assessment tools which determine eligibility for and authorization of LTSS and waiver services.

Actively practicing practitioners are involved in the development and adoption of criteria specific to their area of expertise.

When specific criteria are not available, reviewing Medical Directors may use textbooks, evidence-based reviews from the medical literature, or consultation with appropriate specialists to help make Organization Determination / Authorization decisions.

HCS criteria are reviewed, modified and adopted by the UMC at least annually.

Practitioners may review the HCS criteria at Molina or they may request a copy of the criteria of interest.

Molina informs providers about the availability of criteria through the provider newsletter. In addition, practitioners may request copies of criteria by telephone, fax, or email.

Medical Directors or their delegates may modify or waive specific review criteria if necessary to accommodate an individual member need or some special variation in the capabilities of the local delivery system.

Molina describes medically necessary services as services that:

Medicare Services: Are reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR §1395y;

Medicaid Services: Are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Where Medicare and Medicaid Benefits Overlap (e.g., durable medical equipment services) the health plan will apply the definition of medical necessity that is the more generous of the applicable Medicare and Medicaid standards.

A. Inpatient Criteria

InterQual® criteria are utilized for inpatient hospital and concurrent review. Both intensity of service and severity of illness criteria are utilized to determine appropriateness of the admission and to monitor the length of stay. Clinical staff conducts medical necessity reviews telephonically or on-site for all admissions.

The InterQual® criteria are reviewed and purchased annually. Criteria are applied based on the needs of individual members and characteristics of the local delivery system. The criteria are reviewed, modified and adopted by the UMC at least annually.

B. Emergency / Urgent Services

Molina provides coverage for all emergency / Urgent services without an Organization Determination / Authorization per all regulatory requirements. Inpatient admissions resulting from an emergency service require notification to Molina the next business day.

C. Medical Policy

Molina develops internally produced medical policy criteria. Medical policy may be developed for medical, surgical, diagnostic, pharmacy or other services. Medical policies are reviewed, modified and adopted by the UMC at least annually. Medical policies are derived from one or more of the following:

- Current medical literature and peer reviewed publications;
- Existing government and public sector guidelines;
- Commercially available policies;
- Physician comments;
- Community standards of medical practice;
- Standard practice of Health Contractors.

Medical policies are also available and shared with practitioners upon request. Important new policies may be distributed in the practitioners' publication as they are implemented.

D. Information Sources

When evaluating requests for approval, at a minimum, the following information is considered:

- Member demographics and eligibility information;
- Age;
- Co-morbidities;
- Complications;
- History of symptoms and results of physical examination;

- Results of clinical evaluation including appropriate lab and radiology results, co-morbidities and complications;
- Relevant Primary Care Physician (PCP) and/or specialist progress notes of treatment or consultations;
- Psychosocial situation;
- Home environment, when applicable;
- Other information as required by criteria and/or algorithms.

Molina staff also considers characteristics of the local delivery system available for the specific member, such as:

- Availability of skilled nursing facilities, sub-acute care facilities or home care in the service area to support the member after hospital discharge;
- Coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care where needed;
- Local hospitals’ ability to provide all recommended services within the estimated length of stay;
- Any available home and community resources.

V. Timeliness of HCS Organization Determination/Authorizations

Pre-Service determinations are made in a timely manner determined by the member’s clinical situation. All staff is trained regarding the appropriate turn-around times for determinations.

The policy of Molina is to adhere to the following standards for timeliness of utilization determinations based on regulatory requirements for lines of business including Medicare Advantage, D-SNP, Dual Option, Medicaid, and Health Insurance Marketplace:

Medicare/Dual Option Timeliness Standards

UM decision needed	Decision time frame
Standard (non-expedited) Pre-service Determinations	Within 14 calendar days of receipt of request
Urgent Concurrent Review	Within 24 hours of receipt of the request
Expedited Initial Determinations	Within 72 hours of receipt of request
Reopening of Adverse Determination (additional information received)	If meets CMS criteria (MCM Chapter 13 130.1) for reopening.

Medicaid Timeliness Standards (Services not covered by Medicare)

UM decision needed	Decision time frame
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UM decision needed	Decision time frame
Routine (non-expedited) Pre-service Determinations	Within 14 business days of receipt of the request
Expedited / Urgent determination	Within 72 hours of receipt of the request
Urgent Concurrent Review	Within 24 hours of receipt of request

Notification of Medicare and Medicaid UM/CM determinations is outlined in their respective policy and procedures. Including types of communication sent to enrollees and tailored strategies to address communication barriers.

If, after receiving a denial determination, you wish to have a peer to peer conversation or to submit additional information which may change the denial decision, proceed as follows:

- If the original turnaround time for processing the request is not passed, (14 days for standard and 72 hrs. for expedited) Molina will allow a Peer to Peer conversation. During this exchange additional information may be submitted for consideration. Additional information without a Peer to Peer conversation is not allowed. Additional information alone can be submitted when appealing a claim denial.
- Peer to Peer is available for both contract and non-contract providers.
- If the decision cannot be made before the initial turnaround time expires, then the initial decision stands.

VI. Referrals

PCPs are able to refer a member to a contracted specialist for consultation and treatment without a referral request to Molina. A referral is not a requirement of Molina.

VII. Pre-Service Organization Determinations/ Authorizations

Pre-service review provides an opportunity to determine medical necessity and appropriateness of services, procedures and equipment prior to provision of the service. It is also an opportunity to determine if the services, procedures or equipment are a covered benefit of the member's plan.

Requests for pre-service Organization Determination / Authorizations are reviewed against approved decision making criteria, interqual and established medical policy guidelines. Pre-service review is completed by clinical staff and, when required, a Medical Director or other appropriate health professional. When appropriate the Medical Director or other appropriate health professional will consult with the requesting provider. The Medical Director makes all denial determinations. The member, practitioner, PCP, and facility (if indicated) are notified of the adverse determination in writing and, as needed, by telephone.

Services requiring pre-service Organization Determination/ Authorizations are reviewed, updated and adopted annually by the UMC based upon analysis of utilization trends.

Examples of procedures or services requiring pre-service Organization Determination / Authorizations are published in the Molina Prior Authorization Requirement Guide. The guide includes, but is not limited to: elective inpatient admissions, outpatient surgical procedures, diagnostic procedures, specialty pharmacy and medical supplies and equipment.

Pre-service Organization Determination / Authorizations are not required for the following services: emergency and post-stabilization services including emergency behavioral health care, urgent care crisis stabilization, including mental health, urgent support for home and community services, family planning services, preventive services, basic OB / prenatal care, communicable disease services including STI and HIV testing and out-of-area renal dialysis.

Self-Referrals

In addition the Member may self-refer without authorization to the following services:

- Services provided at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Family planning services provided by Qualified Family Planning Providers (QFPPs)
- Women's routine and preventative health care services provided by any women's health specialist contracted with Molina Healthcare. This is in addition to the member's designated primary care provider (PCP) if that PCP is not a woman's health specialist
- Behavioral health services offered through Community Mental Health Centers (CMHCs)
- Substance abuse services offered through Ohio Department of Mental Health & Addiction Services (ODMHAS)-certified Medicaid providers
- Services provided by Certified Nurse Practitioners (CNPs)
- Services provided by Certified Nurse Midwives (CNMs)
- Sexually transmitted disease and HIV testing & counseling

Molina's Pre-service Organization Determination process allows the member and / or provider to request services from the health plan.

Molina provides coverage for second opinions at the request of the member.

Out-of-Network Services

In the event that a qualified specialist is not available within the contracted network; Molina's HCS staff will coordinate the medically necessary services with an appropriately license and credentialed out-of-network (OON) specialist. Molina will offer the OON provider an opportunity to contract with the health plan contingent on the provider meeting all credentialing standards.

VIII. **Pre-admission/Admission Organization Determinations/ Authorizations**

Molina conducts acute admission review within one business day to determine the medical necessity and appropriateness of inpatient hospital stays. Notification of admissions and requests for review may be in writing, by telephone or sent by fax. Elective admission review is conducted within 14 business days of receipt of the request.

National Coverage Determinations (NCD), Local Coverage Determinations (LCD), InterQual®, and/or other applicable criteria are used to determine the medical necessity of the admission and whether treatment could be rendered in an alternate level of care. If the admission does not meet criteria for medical necessity as an inpatient, the HCS staff will negotiate a lower level of care or refer the case to a Medical Director for determination.

IX. **Concurrent Review**

For selected cases, Molina performs concurrent review to determine medical necessity and appropriateness of a continued inpatient stay. The goal of concurrent review is to identify appropriate discharge planning needs and facilitate discharge to an appropriate setting. InterQual® criteria are used as a guideline in performing concurrent review activities. Molina conducts concurrent review throughout the member's stay to assure appropriate transition of care.

The clinical staff collaborates with hospital staff, practitioners and their representatives to ensure that discharge needs are met in a timely manner and continuity of service is provided. Assessments are conducted concurrently, by telephone or fax.

Objectives of concurrent review:

- Services are timely and efficient;
- Determine that a comprehensive treatment plan is established;
- Member is not being discharged prematurely;
- Member is transferred to alternate levels of care when clinically indicated;
- Effective planning and communication of discharge planning/Transition of care;
- Members appropriate for Case Management are identified and referred.

Inpatient hospital case reviews are conducted weekly with the Medical Director, Supervisor and all RN reviewers.

X. **Discharge Planning**

Discharge planning involves a process of communicating with hospitals and practitioners to ensure that a member's needs are met upon hospital discharge, and that the discharge occurs in a timely manner.

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

All hospitalized members receive a discharge review for discharge date, setting, and procedures performed. Emphasis is placed on an appropriate discharge plan to reduce readmissions.

The clinical staff provides a post inpatient discharge follow-up call to members, to support the discharge plan prescribed by the member's physician. The purpose is to assess the member's understanding of their discharge instructions, confirm the necessary follow-up appointments have been scheduled, confirm prescriptions have been filled, and assess the need for further interventions. Post discharge follow up letters are sent to all members and their PCPs after an inpatient admission.

Members with certain conditions may receive up to 30 days of post discharge support from Care Transition staff.

XI. Molina Transitions of Care (TOC) Program

Molina's goal is to have our providers work closely with the Transition of Care team to ensure that our members understand and are able to manage their medications; understand the signs and symptoms of their disease process, and when to call their PCP. In addition, the Care Transition Coaches will mail out personal health records and other member specific information to each member's PCP. We request that the practitioner review this information and communicate any questions or concerns they may have related to supporting our members through the care transition process back to the Care Transition Coach.

To contact the Transition of Care Team please call (855) 322-4079

Molina defines the Transition Programs to include all services required to ensure the coordination and continuity of care from one care setting to another as the member's health status changes. This is accomplished by providing members with the tools and support that promote knowledge and self-management of their condition, and by facilitating improved member and provider understanding of roles, expectations, schedules and goals. Such transitions occur, for example, when a member moves from a home to a hospital as the result of an exacerbation of chronic conditions or moves from a hospital to a rehabilitation facility after surgery.

Molina has two (2) TOC programs: The first program the *Transitions of Care Telephonic Coaching Program* is designed to reach a larger volume of high risk members by attempting one (1) inpatient hospital outreach call and at a minimum three (3) subsequent phone calls within a 4 – 6 week period of time from the date of the member’s initial admission. The *Healthcare Transitions Program* is designed for members to receive two face-to-face contacts – one in the hospital prior to discharge and one at home within 48 hours of discharge targeted at members known to have admitting diagnoses which research has shown have the highest risk for readmission to an in-patient facility. Both programs are administered by a Molina clinical team member in order to facilitate the transition and to coordinate needed services with appropriate providers.

As Molina works with hospitals in demonstrating the increased value of the TOC program in preventing hospital readmissions all TOC activity will move into the face-to-face model.

The aim of the TOC programs includes; preventing hospital readmission, optimal transitioning from one care setting to another and / or identifying an unexpected change in condition requiring further assessment and intervention. Continuity of care post discharge communications may include, but not be limited to, phone calls and follow up letters to members and their Primary Care Physicians (PCPs), specialty providers, other treating providers / practitioners as well as agencies providing long term services and supports (LTSS).

The Molina Transition Programs re-establishes the member’s connection to their medical home by ensuring that an appointment has been scheduled with the member’s Primary Care Physician (PCP) prior to discharge from a hospital. The goal is to arrange an appointment to occur within seven days of discharge. Follow-up phone calls will also be made to support the member.

The transition program will operate within a 30-day framework. Once the care transition process is complete and it is determined the member has ongoing needs, a designated Molina Case Manager will work with the member to address those needs going forward.

Molina will also obtain releases from members when necessary to ensure HIPAA compliance and allow for sharing of relevant information necessary for transitions in care.

Purpose of Molina’s Transition Program

- Effectively transition members from one setting to another by improving member and provider understanding of roles, expectations and goals.
- Fully prepare members to continue care plans from one setting to another, including awareness of the schedule of events, process awareness and points of contact.

- Facilitate the four fundamental elements (described below) designed to produce positive outcomes targeted to improve member health.
- Assist members through transitions and coordinate needed services with appropriate providers.
- Promote member self-management while encouraging empowerment by embracing the concept of “consumer direction” to encourage members to direct their care through personal choice and responsibility.
- Engage members directly so they can retain an active voice in planning treatment and find satisfaction in the process as it develops.

The Molina Transitions Program focuses on four critical elements as the foundation to prepare members for successful transitions adapted from Dr. Eric Coleman’s Model of Care Transitions Interventions (<http://www.caretransitions.org>) (Eric A. Coleman, MD, MPH):

- Medication Management – Molina’s transition staff will assist with the coordination of member medication authorizations as appropriate; provide training to members regarding their medications, and conduct medication reconciliation to avoid inadvertent medication discrepancies. Through its Pharmacy Benefit Manager (PBM), CVS Caremark, Molina will have up-to-date information readily available regarding the member’s current medications and medication history.
- Personal Health Record – Molina’s transitions staff will assist with completion of a portable document with pertinent member history, provider information, discharge checklist and medication record to ensure continuity across providers and settings.
- PCP and/or Specialist Appointments – Molina transitions staff will facilitate appointment scheduling and transportation to ensure members keep follow-up appointments and will help members understand their Personal Health Record and medication record.
- Knowledge of Red Flags – Molina’s transitions staff will ensure members are knowledgeable about and aware of indications that their condition is worsening and how to respond.

Molina Transitions Program Targeted Diagnoses:

The target population for the Molina Transitions Program will include members admitted with the following diagnoses, which research has shown present the highest risk for re-admission to an inpatient facility:

- Asthma;
- Cellulitis;
- Chronic obstructive pulmonary disease (COPD);
- Congestive heart failure (CHF);
- Diabetes;

- Pneumonia; or
- History of serious psychological impairment (psychosis, schizophrenia, bipolar disorder).

Members admitted with the targeted diagnoses will be approached to participate in the Molina Transition Program. Additional secondary criteria will be considered based on acuity and may include, but are not limited to, the following:

- Readmissions for targeted conditions for case management;
- Alzheimer's disease; and
- Parkinson's disease.

Transitions Program Features

During the Molina Transitions Program, identified members receive standardized tools and learn self-management skills for ensuring their needs will be met when their conditions require that they receive care across multiple settings. The program has a high-touch, patient-centered focus with the transitions staff conducting a face-to-face / telephone visit during an inpatient hospitalization and a face-to-face / telephone visit at the member's residence or secondary facility within 48 hours of discharge. Telephone calls are conducted to ensure the member is following the prepared plan, with phone calls taking place within 7, 14, 30 days of member discharge.

Transitions staff 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 re-hospitalization. The primary role of the transitions staff is to encourage self-management and direct communication between the member and provider rather than to function as another health care provider.

Initial contact between the transitions staff and member will be made during the inpatient stay. The Molina transitions staff will perform introductions, explain the program and describe the member's role within the program. The member may elect at this point not to participate in the program.

The transitions staff will verify the provider, member address and telephone number, and provide the member with Molina care transitions information, including contact information to access their Molina representative. All members also receive the toll-free Nurse Advice Line phone number to call if they have questions or concerns after hours.

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

The face-to-face / telephone visit at the member's residence or secondary facility and / or telephone calls are designed to provide continuity across the transition to empower

members to actively engage in managing their care. During these visits / telephone calls, the transitions staff expands upon the information provided in the initial hospitalization contact and will assist the member with completion of their Personal Health Record, which includes their medication record. The transitions staff will also conduct medication reconciliation. A review of red flags, i.e., warning symptoms or signs that the condition is worsening, and education regarding the initial steps to manage these symptoms and when to contact their provider are discussed. The transitions staff will assess the safety of the environment, the member's support network and community connections. The transitions staff receives training in community resource referrals and will assist the member when needed with referrals for items such as food, transportation and clothing. The Interdisciplinary team also includes a Social Worker to assist with community resources if necessary. The Molina Transitions Program fits within Molina's Integrated Care Management Model, which promotes whole-person care. As the transitions program nears completion, Molina's Care transition staff will identify any ongoing needs that a member may have and, if needed, communicate all relevant information to a designated Molina Case Manager who will work with the member to address those needs going forward.

The inpatient and home visits / telephone calls will be conducted by Molina staff or contracted designee. In the event that a contractor is used, the Molina transitions staff will provide oversight and document results in Clinical Care Advance, Molina's case management software application. Documentation of all member transitions of care will occur in Clinical Care Advance, allowing for the capture of pertinent data for reporting purposes.

The table below outlines the triggers that will result in a member's placement into the Molina Transitions Program and the possible interventions.

Triggers for Molina Transitions of Care Program	Interventions
<p>Member exhibits any of the following:</p> <ul style="list-style-type: none"> • Asthma • Cellulitis • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure (CHF) • Diabetes • Pneumonia • Select behavioral health issues • Poly-pharmacy at the time of discharge • Multiple post discharge therapies 	<p>Multiple potential interventions up to 30 days post discharge, including:</p> <ul style="list-style-type: none"> • Support for medication self-management • Personal health record to facilitate communication and continuity across providers and settings • Follow-up to ensure member schedules and completes necessary visits with PCP and specialists • Member educated to recognize signs and symptoms that condition is worsening and how to respond • Follow-up appointment made to take place within seven days of discharge to reconnect with PCP/Medical Home and out-patient mental health as applicable • As needed on-site hospital pre-discharge visit • Post-discharge home visit or telephone call within 24-72 hours as appropriate • Up to three follow-up telephone calls (7,14, and 30 days post discharge)

XII. Care Management

Molina’s providers are an integral part of the Care Management Program and we look to them to be an active participant in the Member’s Interdisciplinary Care Team. Each Case Manager is responsible for sending a Care Plan to the Member and their assigned PCP. The care plans will provide information in multiple areas depending on the goals and care coordination needs of the member. We request that the member’s physician review this information and provide additional observations and information as appropriate to support the member’s care coordination preferences and needs.

To contact the Care Management Team please call (855) 322-4079

Molina Healthcare, Inc. has significant nationwide experience providing care management services to Medicaid and Medicare Advantage, D-SNP, MMP, Medicaid and Health Insurance Marketplace members using processes designed to address a broad spectrum of disabilities and chronic conditions that require the coordination and provision of a wide array of health care services. To ensure that members receive high quality care, Molina uses an integrated care management approach based on empirically validated best practices that have demonstrated positive results in numerous Molina

managed care markets. Research and experience show that a higher-touch, member-centric care environment for at-risk members supports better health outcomes and reduces the need for institutional care.

Molina's Health Care Services (HCS) program is adaptable across state plans. Depending on the terms of specific state Medicaid or Medicare Advantage, D-SNP, MMP, and Health Insurance Marketplace contracts, certain services that are a part of the integrated model, such as behavioral health or long-term care, may be carved out. In other states, these services may be covered by the managed care plan.

Molina strives for full integration of physical health, behavioral health, long term care services and support and social support services to eliminate fragmentation of care and provide a single, individualized plan of care for members. The HCS program consists of four programmatic levels: Level 1 – Health Management for low-risk members; Level 2 – Case Management for medium-risk members; Level 3– Complex Case Management for high-risk members, and Level 4– Complex Case Management for imminent-risk members. Running concurrently with these four levels are the Care Access and Monitoring process, which ensures appropriate and effective utilization of services, and the Molina Transitions Program, which ensures members receive the support they need when moving from one care setting to another. Mental health, chemical dependency, and long-term care are integrated throughout all aspects of the Health Care Services program. Through continuous process and technology improvements, Molina streamlines interactions between all Care Management teams to promote highly effective collaborations that result in optimized member care.

Identifying At-Risk Members

Molina identifies at-risk members who may benefit from Care Management through an analysis of all available data which may include encounter forms, claims data, member health risk assessments and pharmacy claims, data provided by CMS and/or the Ohio Department of Jobs and Family Services as well as through internal and external referrals. The selection criteria are based on the current literature and Molina's experience with its members creating a focused, results-oriented approach to identification and interventions.

For higher need members, the selection criteria include one or more of the following: recent utilization for selective chronic conditions, several co-morbidities, high risk maternity, or a history of high costs. Selection criteria for members with lower level needs include a request for or existing use of Long Term Supports and Services (LTSS), recent utilization for selective chronic conditions, pharmacy utilization, abnormal lab results, missed preventive services, or other health management needs such as smoking cessation or weight management. These criteria define the trigger lists which are then prioritized using member prospective risk scores from Molina's current predictive modeling tool. Prioritization is further refined to include admission and emergency department visit counts, co-morbidity counts, and high cost amounts. Molina members

will benefit from this prioritization process since immediate attention is focused on those who are in greatest need and likely to benefit from intensive care management.

In addition, referrals of at-risk members may come from providers, internal Molina resources such as the Nurse Advice Line, or from the members themselves.

Members identified through these various channels as potentially requiring care management services are then contacted by a Molina Case Manager to further assess their unique needs and verify if enrollment in Care Management is appropriate. This process also includes assigning the level of care for the member based on applying clinical protocols and conducting assessments.

To further refine and streamline the risk-stratification process, Molina continues to explore innovative solutions, including cutting edge predictive modeling technology.



Risk Stratification

Each member identified as being at risk is evaluated through a risk stratification process to determine the appropriate level of intervention needed: Health Management, Case Management, or Complex Case Management. For all levels, the focus of the interventions is to provide member education and/or to coordinate access to services which clinical peer-reviewed literature and Molina’s own multi-decades of experience have shown improve health outcomes. The intensity of interventions provided increases for each subsequent level.

Care Management

Molina has conducted extensive research of current literature to identify the factors that increase the likelihood of hospitalization, costly medical expenses, or poor health outcomes for members. Using this information, Molina has updated its criteria that trigger member placement into the various levels of Care Management. All Molina state health plans are currently using the updated list of Care Management triggers and the three new Care Management levels.

Based on the level of Care Management needed, outreach is made to the member to determine the best plan to achieve short and long-term goals. Each level of the HCS program has its own specific health assessment used to determine interventions that support member achievement of short- and long-term goals. At the higher levels, this includes building an individualized care plan with the member and/or representative. These assessments include the following elements based on NCQA, state and federal guidelines:

- Health status and diagnoses;
- Clinical history;
- Medications prescribed;
- Activities of daily living, functional status, need for or use of LTSS
- Cultural and linguistic needs;
- Visual and hearing needs;
- Caregiver resources;
- Available benefits and community resources;
- Life-planning activities (e.g., health care power of attorney, advance directives);
- Body Mass Index;
- Smoking;
- Confidence;
- Readiness to change;
- Member's desire / interest in self-directing their care;
- Communication barriers with providers;
- Treatment and medication adherence;
- Emergency Department and inpatient use;
- Primary Care Physician visits;
- Living situation;
- Psychosocial needs (e.g., food, clothing, employment);
- Durable medical equipment needs;
- Health goals;
- Mental health; and
- Chemical dependency.

The resulting care plan is approved by the member, maybe reviewed by the Interdisciplinary Care Team (ICT) and maintained and updated by the Case Manager as the member's condition changes. The Case Manager also addresses barriers with the

member and/or caregiver, and collaborates with providers to ensure the member is receiving the right care, in the right setting, with the right provider.

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

Level 1 – Health Management

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

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

The table below outlines the key triggers that result in a member's placement into Level 1 – Health Management and the possible interventions. The triggers and interventions listed are not all inclusive. A member may be placed in this level based on other clinical needs or provider recommendation. If at any time a member requires a different level of care, a reassessment of risk is conducted and a new plan is made for the administration of the appropriate level of interventions.

Triggers for Health Management	Interventions
<p>Member has one inpatient admission or three Emergency Department visits within the previous six consecutive months with specific conditions. Targeted diagnoses include:</p> <ul style="list-style-type: none"> • Asthma • Cardiovascular • Congestive heart failure (CHF) • Chronic obstructive pulmonary disease (COPD) • Diabetes <p>Member exhibits needs for any of the following:</p> <ul style="list-style-type: none"> • Education support for health care/ pharmacotherapy • Home and community based services • Transportation assistance • High-risk social/behavioral health or substance abuse services • Smoking cessation • Dietary assistance • Outreach regarding HEDIS missed services 	<p>Interventions customized to member's needs may include:</p> <ul style="list-style-type: none"> • Health education • Medication education to ensure adherence to appropriate pharmacotherapy treatment plans • Healthy lifestyle management techniques • Informational booklets for key conditions (e.g., COPD, depression, diabetes) • Service Coordination including transportation coordination, appointment scheduling and durable medical equipment coordination • Referral to community or external resources • Behavioral health coordination

Level 2 – Case Management

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

The table below outlines the key triggers that result in a member’s placement into Level 2 – Case Management and the possible interventions. The triggers and interventions listed are not all inclusive. A member may be placed in this level based on other clinical needs or provider recommendation.

Triggers for Case Management	Interventions
<p>Member exhibits any of the following:</p> <ul style="list-style-type: none"> • Predictive modeling risk score • Two inpatient admissions and three ER visits within the previous six consecutive months Range of three to four co-morbidities. • Targeted diagnoses include: <ul style="list-style-type: none"> ○ Asthma ○ AIDS/HIV ○ Cancer (other than chemotherapy admissions) ○ Cardiovascular ○ Congestive heart failure ○ Chronic obstructive pulmonary disease ○ Diabetes ○ End-stage renal disease ○ Sickle cell anemia ○ High-risk pregnancy or newborn ○ Mental health diagnoses ○ Chemical dependency 	<p>Interventions customized to member’s needs include:</p> <ul style="list-style-type: none"> • Use of standardized assessments to determine member needs • Development of care plan with prioritized goals • Ongoing telephonic member contact • Care Coordination including mental health, chemical dependency, and long-term care services, LTSS • Focused health education and coaching to promote self-management • Coordinated interdisciplinary approach involving internal staff, providers, member/family and community resources • Service Coordination including arranging transportation, scheduling appointments, and attaining durable medical equipment • Referral to community or external resources

Level 3 – Complex Case Management

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

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

The table below outlines the key triggers that result in a member’s placement into Level 3 – Complex Case Management and the possible interventions. The triggers and interventions listed are not all inclusive. A member may be placed in this level based on other clinical needs or provider recommendation.

Triggers for Complex Case Management	Interventions
<p>Member exhibits any of the following:</p> <ul style="list-style-type: none"> • Predictive modeling risk score • High-risk chronic illness with clinical instability as demonstrated by three or more admissions or six or more ER visits within a six month period • Five or more co-morbidities • Targeted diagnoses include: <ul style="list-style-type: none"> ○ Asthma ○ AIDS/HIV ○ Cancer (other than chemotherapy admissions) ○ Cardiovascular ○ Congestive heart failure ○ Chronic obstructive pulmonary disease ○ Diabetes ○ End-stage renal disease ○ Sickle cell anemia ○ Mental health diagnoses ○ Chemical dependency • Expected annual expenditures of 	<p>Interventions customized to member’s needs include:</p> <ul style="list-style-type: none"> • Use of standard assessments to determine member needs • Development of care plan with prioritized goals • Ongoing telephonic and face-to-face member contact, including home visits • Care Coordination with mental health, chemical dependency, and long-term care services, LTSS • Focused health education and coaching to promote self-management • Coordinated interdisciplinary approach involving internal staff, providers, member/family and community resources • Service Coordination including arranging transportation, scheduling appointments, and attaining durable

Triggers for Complex Case Management	Interventions
\$100,000 or greater	medical equipment <ul style="list-style-type: none"> • Coordination with community-based organizations and services for housing, food assistance, supported employment, etc.

Level 4 – Imminent Risk

Level 4 focuses on members at imminent risk of an emergency department visit, an inpatient admission, or institutionalization, and offers additional high intensity, highly specialized services. Level 4 also includes those members who are currently institutionalized but qualify to transfer to a home or community setting. Populations most often served in Level 4 are the Dual-Eligibles (Medicare/Medicaid), those with severe and persistent mental illness (SPMI), those with Dementia, and the Developmentally Delayed. These services are designed to improve the member’s health status and reduce the burden of disease through education as described in level 1.

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

Comprehensive assessments of Level 4 conditions include assessing the member’s unique health needs utilizing the comprehensive assessment tools, identify potential transition from facility and need for LTSS referral coordination, participate in ICT meetings, create individualized care plans with prioritized goals, and facilitate services that minimize barriers to care for optimal health outcomes.

Level Four Identification Criteria:

High-risk chronic illness with clinical instability as demonstrated by five or more admits in six months related to:

- CVD;
- CHF;
- COPD;
- ESRD;
- Asthma;
- Diabetes;
- Sickle Cell;
- AIDS/HIV;
- Cancer;
- Behavioral Health (Specific codes);
- Imminent risk of:

- Inpatient admission (Psychiatric or medical) related to inability to self-manage in current living environment;
- Institutionalization (state psychiatric hospital or nursing home).
- Needs assistance with four or more Activities of Daily Living and Independent Activities of Daily Living and lacks adequate care giver assistance;
- Long term nursing facility residents with potential to transition safely to community setting;
- Hospice Services.

Triggers for Imminent Risk Case Management	Interventions
Member exhibits any of the following: <ul style="list-style-type: none"> • loss of current living arrangement • deterioration of mental or physical condition • fragile or insufficient informal caregiver arrangements • having a terminal illness • having multiple other high risk factors. 	Interventions customized to member’s needs include: <ul style="list-style-type: none"> • referral for housing assistance • Arrangements for private duty nursing or aid assistance • Hospice • Individualized member care plan • LTSS referral and coordination

XIII. Continuity of Care

Molina ensures continuity of care for members in an “active course of treatment” for new members or for existing members in situations where there is a discontinuation or lack of a contract between Molina and the treating practitioner. Continuity of Care policies and procedures provide additional detail.

Additionally, the UM/CM staff facilitate the transition of care for members whose benefits have come to end. Alternatives to coverage are explored with the member, the PCP, community resources and any new coverage to ensure continuity of care.

XIV. Disease/Health Management

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 Dual Options Plan 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 Diabetessm Program
- Healthy Living with Chronic Obstructive Pulmonary Disease
- Breathe with Easesm Asthma Program
- Motherhood Matters Program
- Smoking Cessation

The goal of the Disease Management Program is to improve clinical outcomes through continual, rather than episodic, care and enable members to manage their symptoms optimally and improve their quality of life.

XV. Adverse Determination/Denial Process

The process of review, utilizing established criteria, encompasses initial clinical review, Medical Director review and Specialist review. Services that do not meet medical necessity criteria are reviewed by a health professional – a Medical Director or pharmacist.

The review and denial process consists of the following:

1. Initial clinical review is performed by UM/CM licensed staff who reviews for medical necessity according to benefit guides and clinical criteria (e.g. CMS Medical Coverage Guidelines, Local and National Coverage Determinations, InterQual® or other approved guidelines). If criteria are met, the services are approved. If a service does not meet criteria or if the criteria specifically require Medical Director review, the reviewer submits the case to a physician.
2. Health Professional review is conducted by a Molina Healthcare Medical Director or clinical peer (e.g., a pharmacist). Physician-to-physician or peer-to-peer discussion is made available prior to issuing the adverse determination letter, whenever possible. The health professionals with Molina are competent board-certified practitioners (pediatrics, general internal medicine, or family practice) or pharmacists (Pharm D)
3. Specialist clinical review utilizes a physician who has not been involved in the case review previously. The specialist review is conducted by a physician who is a board-certified specialist of the same or similar specialty that typically manages the condition, procedure or treatment under review. Specialist reviews may be requested by a Medical Director at any time. Specialist reviews may also be utilized in the appeal process.

4. All adverse determinations may be communicated to the requesting practitioner and member verbally or in writing based on certification and regulatory requirements. Timeframe requirements for communication of denials are established in accordance with regulatory and accrediting requirements. Member communications are tailored to member's individual communication needs, barriers and requirements (e.g., language interpretation, aids for low vision and / or deaf / hard of hearing, etc.). Adverse determination notifications include the rationale for the determination in plain terms and cite the utilization criteria or benefit provisions used in making the determination. UM/CM denial letters also provide information about the member's appeal rights, how to use the appeals process and the various levels of review that are available to Medicare beneficiaries under Federal law.

XVI. **Retrospective Review/Post-Service Review**

A. Standards for Retrospective Review

Retrospective Review/Post-Service Review applies when a provider fails to seek an Organization Determination / Authorization from Molina for services that require Organization Determination / Authorization. Failure to obtain an Organization Determination / Authorization for an elective service that requires Organization Determination / Authorizations may result in a denial. Emergent services do not require an Organization Determination/ 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, notification is required within one business day or post stabilization stay will be denied.

If information is received indicating the provider did not know nor reasonably could have known that patient was a Molina member or there was a Molina error, a medical necessity review will be performed. Decisions, in this circumstance, will be based on medical need; appropriateness of care guidelines defined by CMS Medical Coverage Guidelines, Local and National Coverage Determinations, Medicaid Coverage Guidelines, UM/CM policies and criteria, and InterQual® criteria.

B. Practitioner Monitoring Activities

Practitioner monitoring activities includes trend analysis of practitioner practice patterns to identify aberrant practitioners. The Medical Director uses this information in communicating practice patterns to physicians.

XVII. Compensation/Conflict of Interest

Molina ensures through communications to providers, practitioners, members and Molina staff that the health plan and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to members.

XVIII. Confidentiality

Molina is committed to preserving the confidentiality of its members and practitioners. Written policies and procedures are in place to ensure the confidentiality of member information and records. Member information gathered to facilitate utilization reviews and claims administration is available only for the purposes of review and is maintained in a confidential manner.

Records requested from practitioners are those which will provide relevant information to complete a review or facilitate adjudication of claims. UM/CM policy and procedure includes appropriate storage and disposal of confidential information. Documents of a sensitive or confidential nature are shredded prior to disposal.

Employees receive and sign a confidentiality agreement at the time of their initial company orientation.

All minutes, reports, medical records, worksheets and other data are maintained in a manner ensuring strict confidentiality.

XIX. Integration with Other Departments

The UM/CM staff and Medical Directors plan, coordinate and direct the UM/CM Program. Representatives from the UM/CM and QI Departments participate in the UM/CMC and QIC. Identification of quality issues and UM/CM trends are reported to QI. UM/CM issues that are reviewed during the QI process are reported to UM/CM via the committee structure.

Quality Improvement:

UM/CM and QI activities are linked by review of surveys, reports, trends and studies of UM/CM practices. The UM/CMC reviews data and is attended by representation from the QI Department. Data collection is reported through the committee process and is

returned to QI for development of practice standards and quality improvement plans to improve outcomes.

Provider Services:

The Medical Director and UM/CM VP / Director collaborate with the Provider Services department to ensure that Molina's UM/CM Program requirements are appropriately communicated to all providers and any identified over or under-utilization trends are appropriately communicated and addressed.

Member Services:

UM/CM Department leadership collaborates with the Member Services Department to ensure that information regarding Molina member utilization concerns is known by the UM/CM Department and resolved by the appropriate staff.

XX. Practice Guidelines

Molina utilizes nationally recognized, standardized, validated medical practice guideline sets which are based on current scientific knowledge and clinical experience and take into consideration the needs of the member and dynamic state of medical/health care practices. All practice guidelines are approved by the Clinical Quality Management Committee (CQMC) and reviewed and adopted for use by the UMC annually.

XXI. Evaluation of New Technological and Scientific Advances

The UM/CM Department performs assessment of the appropriate use of new medical technologies or applications of established technologies including procedures, drugs, equipment and devices through participation on the Molina Healthcare Corporate Medical Coverage Guidance Committee.

Various resource criteria, including the Hayes Directory are utilized in the evaluation process. Organization Determination / Authorizations and coverage decisions from this committee are added to the list of services requiring an Organization Determination / Authorization when appropriate. Individual requests for services that are potentially investigational or experimental are evaluated on an individual basis through the Organization Determination / Authorization process.

New technology guidelines are reviewed and approved for adoption by the UMC quarterly.

XXII. Delegation of UM/CM Activities

Molina may delegate UM/CM functions to contracted health plan partners based on their ability to meet and maintain specific delegation criteria. Health plan partners will be granted full or partial delegation of UM and/or CM functions.

Molina retains accountability for UM/CM and DM activities that are delegated to the subcontracted providers and health plan partners.

In order to receive delegation status for UM/CM or DM activities the delegate must demonstrate ongoing, functioning systems are in place and meet the required UM/CM or QI standards based on NCQA and state and federal regulations. There must be a mutually agreed upon written delegation agreement describing the responsibilities of Molina and the delegated entity. Delegation of selected functions may occur only after an initial audit of the proposed delegated activities has been completed and there is evidence that the Molina delegation requirements are met. These requirements include; a written description of the specific delegated activities, reporting requirements, evaluation mechanisms, and remedies available to Molina if the delegated entity does not fulfill its obligations. The Delegation Oversight findings are presented to the UM/CMC to make the decision for granting initial delegation, continuation of delegation, additional corrective action or revocation of the delegation status. The final determination is reported to the Delegation Oversight Committee, Quality Improvement Committee, or other applicable committee.

Delegated entities are required to submit their UM/CM Program, policies and procedures, work plan and annual review pre-contractually and annually thereafter. Delegated entities participate with Molina's oversight activities by meeting mutually agreed upon performance standards.

Health plan staff is responsible for systematic monitoring of each delegated health plan partner to ensure their ability to perform the delegated functions and adherence to all applicable regulatory and accreditation standards. Health plan staff conduct at least annually; or more frequently audits of the delegated entity to ensure compliance with the Molina delegation requirements.

XXIII. Monitoring for Over And Under Utilization

The UM/Case Management Coordinator (CMC) monitors and analyzes utilization data for over and under utilizations of UM resources. These monitors include, but may not be limited to, emergency room utilization, bed days / K, pharmacy utilization and average length of stay per product line.

Data is reported to the UM/CMC for review and discussion on a quarterly basis. The UM/CMC recommends interventions when a trend is identified and monitors the efficacy of the intervention taken.

The QI and UM Departments collaborate in the monitoring of utilization patterns across practices and provider sites including primary care practitioners and high volume

specialists. These activities include monitoring all potential quality issues related to over or under utilization of services.

XXIV. Program Planning and Evaluation

The written HCS Program is reviewed, evaluated and updated at the health plans annually under the direction of the state UM/CMC and Quality Information Coordinator (QIC). A quantitative and qualitative analysis is completed to identify barriers and assess if annual goals were met. Corrective action plans will be developed for goals that are not meet.

VIII. Long Term Care and Services

A. Home and Community Based Programs

The Home and Community-Based Services (HCBS) Long Term Services and Support (LTSS) waiver program offers service packages to individuals whose care needs would otherwise qualify them for Medicaid-funded institutional care in nursing homes, hospitals or intermediate care facilities for those with mental retardation (IC/MR)

LTSS benefits are provided over an extended period, mainly in member homes and communities, but also in facility-based settings such as nursing facilities as specified in his/her Individualized Care Plan. Overall, Molina's care team model promotes improved utilization of home and community-based services to avoid hospitalization and nursing facility care. Molina case managers will work closely with LTSS centers and staff to expedite evaluation and access to services.

Molina Dual Options program available to members provides seamless coordination between medical care, LTSS, and mental health and substance use benefits covered by Medicare and Medicaid. Much of this coordination requires a partnership between Molina and various county agencies that provide certain LTSS benefits and services.

The program offers a broad range of personal, social and medical services that assist people who have functional or cognitive limitations in their ability to perform self-care and other activities necessary to live independently. The program also offers support to family caregivers.

Services that are available through the HCBS include:

- Adult day care
- Home Care Attendant
- Chore Services
- Home Delivered Meals
- Independent Living Assistance Services
- Nutritional Consultation Services
- Pest Control Services
- Social Work Counseling Service
- Waiver Transportation Services
- Assisted Living Services
- Enhanced Community Living Service
- Home Medical Equipment and Supplemental Adaptive and Assistive Devices
- Home Modification Maintenance and Repair
- Personal Care Aide Services
- Waiver Nursing Services

- Homemaker Services
- Personal Emergency Response
- Out of Home Respite Care Services
- Community Transition Services
- Alternative Meal services

B. Behavioral Health and Substance Use Services

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

C. Ohio Medicaid Health Homes for Individuals with Serious and Persistent Mental Illness (SPMI)

Health homes aim to integrate physical and behavioral health care by offering and facilitating access to medical, behavioral and social services that are timely, of high quality and coordinated by an individualized care team. Ohio Medicaid teamed up with the Ohio Department of Mental Health and Addiction Services (ODMHAS) to focus on creating Health Homes for individuals on Medicaid who have serious and persistent mental illness (SPMI).

A Health Home is not a building; it is a coordinated, person-centered system of care. An individual who is eligible for health home services can obtain comprehensive medical and mental health care, drug and/drug alcohol addiction treatment, and social services that are coordinated by a team of health care professionals. The following health home services are available for individuals with SPMI:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services

Community Mental Health providers that meet state-defined requirements, including integration of primary and behavior health care services, can qualify as health homes. Below are the requirements for providers and members:

Provider Eligibility

- ODMHAS certified community mental health centers (CMHCS) become certified to provide the Health Home service for SPMI members by meeting requirements as set forth in the State Plan Amendment and Ohio Administrative Code

Member Eligibility

- Adults and children who meet the State of Ohio definition of severe and persistent mental illness (SPMI), which includes adults with serious mental illness and children with serious emotional disturbance, are eligible for health home services in community mental health agencies

Coordination and a relationship between the health home and the Managed Care Plan (MCP) are key to the programs' success. All health home services will be provided by the health home provider, who will work with MCP's and collaborate with MCP panel providers and clinicians.

Currently, Ohio Medicaid Health Home Service Providers for Individuals with Serious & Persistent Mental Illness are as follows:

- Shawnee Mental Health Center
- Butler Behavioral Health Services
- Harbor
- Unison Behavior Health Group
- Zepf Center
- Family Services of Northwest Ohio

Please visit The Ohio Department of Mental Health and Addiction Services website for additional information about health homes at: <http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/medicaid/hhc-main.shtml>

IX. Behavioral Health and Alcohol and Other Drug Treatment Services

Behavioral health counseling and therapy services means interaction with a person serviced in which the focus is on treatment of the person's mental illness or emotional disturbance. When the person served is a child or adolescent, the interaction may also be with the family members and/or parent, guardian and significant others when the intended outcome is improved functioning of the child or adolescent and when such interventions are part of the Individualized Plan (ISP).

Managed care mentally ill beneficiaries has the potential to improve service coordination, provider greater flexibility in types of services that are provided, and help to control costs through reduced reliance on hospitalization and institutionalization.

A. **Rendering Service Provider Specialties**

Behavioral health counseling and therapy services shall be provided and supervised by staff that is qualified according to the rule 5112-29-30 of the Administrative Code. This rule can be found here: <http://codes.ohio.gov/oac/5122-29-30>

B. **Behavioral Health Services**

Behavioral health counseling and therapy service shall consist of a series of time-limited, structured sessions that work toward the attainment of mutually defined goals as identified in the ISP.

Covered services include:

Community Behavioral Health

- Behavioral Health Counseling – Individual and Group
- Community Psychiatric Support Treatment – Individual and Group
- Crisis Intervention
- Mental Health Assessment – Physician and non-Physician
- Partial Hospitalization
- Pharmacological Management

Alcohol and Other Drug Treatment Services

- Assessment
- Alcohol Drug Screening analysis/Lab urinalysis
- Case Management
- Counseling – Individual
- Counseling – Group
- Ambulatory Detoxification
- Crisis Intervention

- Intensive Outpatient
- Medical/Somatic
- Methadone Administration

C. Member Eligibility Requirements

Any eligible MyCare Ohio recipient currently receiving services for alcohol or other drug treatment and/or mental health services from a community provider will have the option to continue to receive care from their existing provider during the transition period.

Member Transition of Care Process

Molina Healthcare will, whenever possible, use fee-for-service (FFS) data files obtained from ODM for incoming Molina MyCare Ohio members. These files will contain information to identify any form of current behavioral health services received during the year preceding enrollment. If identified prior to the enrollment start date, Molina will prioritize MyCare Ohio members who have received behavioral health services in the past year for comprehensive needs. This will ensure assessments occur for high risk members within the first 30 days of membership, and allow for verification of the both the services received and current provider information.

If a MyCare Ohio member is identified as being in the course of behavioral health treatment with a non-contracted provider or agency, Molina Care Management staff will make outreach attempts to contact the provider to communicate for the purpose of care coordination. In the event a service needs to be added or increased on the existing plan of care, this outreach communication will include a review of the process for submitting service requests.

Additionally, Molina Care Management staff will request a copy of the existing plan of care that outlines all active BH services a member is receiving from the provider. When an existing plan of care is received at the start of the transition of care (TOC), Molina Utilization Management (UM) staff will be notified to build authorizations in the Molina claims and benefits configuration system. A copy of the existing plan of care plan will be made available to CM staff, as well as in the UM clinical database. UM staff will use this information for claims adjudication purposes as needed. Existing plan of care will be interpreted to mean existing treatment plan. Such treatment plans will be reviewed and amended every 90 days. Molina Care Management staff will be available to consult with UM staff as needed for clinical guidance to determine when BH services need to be authorized if they fall outside of the TOC requirements.

Please see the following chart for the TOC guidelines.

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not identified for LTC Services

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not identified for LTC Services
Medicaid Community Behavioral Health Organizations (Provider types 84 & 95).	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.

When members are identified as being in the active course of treatment with a non-contracted provider, Molina Care Management staff will document the provider and services in the member’s care plan and attempt to have regular communication with the BH provider regarding the member’s care plan. These outreach efforts will include telephonic outreach for input on the health risk assessments and care plan. In addition Molina will mail both notices regarding care management services, and a copy of the current care plan, as well as conduct in-person visits to community behavioral health provider agencies as necessary.

Molina Care Management staff will use a collaborative approach when scheduling in order to involve behavioral health providers in ICT meetings as much as possible. In many cases, behavioral health providers have the most contact with members receiving behavioral health services and are therefore important members of the ICT. Moreover, they may be critical in some cases to keeping members engaged in the ICT process and may play an important role in encouraging members to attend ICT meetings.

D. Crisis Intervention

Crisis intervention is the process of responding to emergent situations and may include: assessment, immediate stabilization, and the determination of level of care in the least restrictive environment in a manner that is timely, responsive, and therapeutic.

Crisis intervention mental health services need to be accessible, responsive and timely in order to be able to safely de-escalate an individual or situation, provide hospital pre-screening and mental status evaluation, determine appropriate treatment services, and coordinate the follow through of those services and referral linkages.

Outcomes may include: de-escalating and/or stabilizing the individual and/or environment, linking the individual to the appropriate level of care and services including peer support, assuring safety, developing a crisis plan, providing information as appropriate to family/significant others, and resolving the emergent situation.

Crisis intervention mental health service shall consist of the following required elements:

- Immediate phone contact capability with individuals, parents, and significant others and timely face-to-face intervention shall be accessible twenty-four hours a day/seven days a week with availability of mobile services and/or a central location site with transportation options. Consultation with a psychiatrist shall also be available twenty-four hours a day/seven days a week. The aforementioned elements shall be provided either directly by the agency or through a written affiliation agreement with an agency certified by ODMHAS for the crisis intervention mental health service;
- Provision for de-escalation, stabilization and/or resolution of the crisis;
- Prior training of personnel providing crisis intervention mental health services that shall include but not be limited to:
 - risk assessments,
 - de-escalation techniques/suicide prevention,
 - mental status evaluation,
 - available community resources, and procedures for voluntary/involuntary hospitalization.
 - training and/or certification in first aid and cardio-pulmonary resuscitation (CPR) unless other similarly trained individuals are always present; and
 - Policies and procedures that address coordination with and use of other community and emergency systems.

All Medicaid community mental health services are to be billed on a unit rate basis in accordance with definitions, standards and eligible providers of service requirements as set forth in Chapter 5101:3-27 of the Administrative Code.

A crisis plan will be established that includes referral and linkages to appropriate services and coordination with other systems. The crisis plan should also address safety issues, follow-up instructions, alternative actions/steps to implement should the crisis recur, voluntary/involuntary procedures and the wishes/preferences of the individual and parent/guardian, as appropriate.

Crisis Prevention and Behavioral Health Emergencies

Please contact our Nurse Advice Line available 24 hours a day, 7 days a week at (888) 275-8750

E. **Community Psychiatric Supportive Treatment**

Community psychiatric supportive treatment (CPST) service's purpose is to provide specific, measurable, and individualized services to each person served. CPST services should be focused on the individual's ability to succeed in the community; to identify and access needed services;

and to show improvement in school, work and family, and integration and contributions within the community.

Activities of the CPST service shall consist of one or more of the following:

- Ongoing assessment of needs;
- Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent or guardian;
- Facilitation of further development of daily living skills, if identified by the individual and/or parent or guardian;
- Coordination of the ISP, including:
- Services identified in the ISP;
- Assistance with accessing natural support systems in the community; and
- Linkages to formal community service/systems;
- Symptom monitoring;
- Coordination and/or assistance in crisis management and stabilization as needed;
- Advocacy and outreach;
- As appropriate to the care provided to individuals, and when appropriate, to the family, education and training specific to the individual's assessed needs, abilities and readiness to learn;
- Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining education and employment; and
- Activities that increase the individual's capacity to positively impact his/her own environment.

For CPST services not rendered in a group setting, the Medicaid maximum amount is calculated as follows:

- If the total number of service units rendered by a provider per date of service is less than or equal to six, the Medicaid maximum amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units rendered.
- If the total number of services units rendered by a provider per date of service is greater than six, the Medicaid maximum amount is equal to the sum of:
- The unit rate according to the department's service fee schedule multiplied by six; and
- Fifty per cent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units rendered minus six.

For CPST services rendered in a group setting, the Medicaid maximum amount is calculated as follows:

- If the total number of service units rendered by a provider per date of service is less than or equal to six, the Medicaid maximum amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units rendered.
- If the total number of services units rendered by a provider per date of service is greater than six, the Medicaid maximum amount is equal to the sum of:

- The unit rate according to the department's service fee schedule multiplied by six; and
- Fifty per cent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units rendered minus six.

A combined maximum of one-hundred and four hours (416 units) of individual and group CPST services are allowed per twelve month period. In accordance with the Healthchek benefit, children up to age of twenty-one may receive services beyond established limits when medically necessary and approved through the prior authorization process (modifier TJ). Adults may receive services beyond established limits when medically necessary and approved through the prior authorization process.

As of July 1,2011, after the first 6 units (90 minutes) of service provided to the same consumer by the same provider on the same day, additional units will be reimbursed at 50% of the rate.

CPST services are not covered under this rule when provided to an adult or child in a hospital setting, except for the purpose of coordinating admission to the inpatient hospital or facilitating discharge to the community following inpatient treatment for an acute episode of care. Providers may use POS 99 (other place of service) when billing CPST for this particular circumstance.

F. **Partial Hospitalization**

Partial hospitalization is an intensive, structured, goal-oriented, distinct and identifiable treatment service that utilizes multiple mental health interventions that address the individualized mental health needs of the client. Partial hospitalization services are clinically indicated by assessment with clear admission and discharge criteria. The purpose and intent of partial hospitalization is to stabilize, increase or sustain the highest level of functioning and promote movement to the least restrictive level of care. The outcome is for the individual to develop the capacity to continue to work towards an improved quality of life with the support of an appropriate level of care.

Partial hospitalization services includes activity therapies, group activities, or other services and programs designed to enhance skills needed for living in the least restrictive environment are allowable.

A partial hospitalization program day shall consist of a minimum of two hours and up to a maximum of seven hours of scheduled intensive activities

Unallowable partial hospitalization activities include, but are not limited to, crafts, general non-therapeutic art projects, recreational outings purely for recreational purposes, exercise groups, etc.

G. **Prior Authorization and Referral Guidelines**

How to refer Molina Healthcare members in need of Mental Health/Behavioral Health services

- Refer to Molina Healthcare Prior Authorization requirements at www.MolinaHealthcare.com
- Behavioral health participating providers should fax the Molina Healthcare Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form to Molina Healthcare as soon as possible to (866) 553-9262.
- For both participating and non-participating providers, if the request is for Inpatient Behavioral Health, Partial Hospitalization, or an Intensive Outpatient Program for psychiatric and substance use disorders, the Molina Healthcare Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form should be faxed as soon as possible to the same number at (866) 553-9262.
- If the admission to Inpatient Behavioral Health is an emergency, prior authorization is not needed but the form should be faxed as soon as possible to (866) 553-9262.
- The Molina Healthcare Behavioral Health RN may call the behavioral health provider for additional clinical information, particularly if the Molina Healthcare Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form is not completely filled out.
- Interqual® medical necessity criteria is used to review the provided clinical information. The Molina Healthcare psychiatrist may also contact the behavioral health provider for a peer-to-peer discussion of the member behavioral health needs.
- All Requests for Prior Authorization will require the current and existing treatment plan that identifies all medical and behavior health services known.

X. Members' Rights and Responsibilities

Molina Medicare's Dual Options Plan members have certain rights to help protect them. In this chapter, Member rights and responsibilities are outlined based on Molina Medicare of Ohio's Evidence of Coverage document that members receive annually.

A. Molina Dual Options Plan Members have a right to:

1. Members have the right to be treated with respect and recognition of their dignity by everyone who works with and for Molina Dual Options program.
2. Members have the right to receive information about Molina Dual Options program, covered benefits, our providers, our doctors, our services and member's rights and responsibilities.
3. Members have the right to choose their primary care physician (PCP) that gives care whenever possible and appropriate from Molina Dual Options network and the provision to change PCP on the Molina Dual Options network at least monthly. Molina Dual Options program must communicate all changes in writing as to who the new PCP is and the effective date of change.
4. Members have the right to receive and/or to authorize representative(s) to obtain information about their health in simple and understandable terminology and/or nominate contact(s) to be reached in case of emergency. If members are ill, members have the right to be told about treatment options regardless of cost or benefit coverage. Members have the right to have all questions about their health answered.
5. Members have the right to help make decisions about their health care. Members have the right to refuse medical treatment.
6. Members have the right to privacy. Molina, its Staff and affiliates keeps their medical records private in accordance with State and Federal laws.
7. Members have the right to see their medical record. Members have the right to receive a copy of their medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
8. Members have the right to complain about Molina Dual Options program or their care by calling, faxing, e-mailing or writing to Molina Dual Options Member Services Department.
9. Members have the right to appeal Molina Dual Options decisions. Members have the right to have someone speak for them during the grievance.
10. Members have the right to disenroll from Molina Dual Options.
11. Members have the right to ask for a second opinion about their health condition from a qualified provider on Molina Healthcare's plan. If the qualified provider is not able to provide service to member, Molina Dual Options must set up a visit with a provider not on our panel. These services are available at no extra cost to member.
12. Members have the right to ask for an external independent review of experimental or investigational therapies.
13. Members have the right to decide in advance directives (a living will) on how they want to be cared for in case they have a life-threatening illness or injury.
14. Members have the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

15. Members have the right to receive interpreter services at no cost to help them talk with their doctor or Molina Dual Options interpreter if they prefer to speak a language other than English and get help with sign language if hearing impaired.
16. Members have the right to not be asked to bring a friend or family member with them to act as their interpreter.
17. Members have the right to receive information about the Molina Dual Options program, their providers, or their health in their preferred language free of charge. Members have the right to request information in printed form translated into their preferred language.
18. Members also have the right to request and receive informational materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested at no cost to member.
19. Members have the right to receive a copy of Molina Dual Options program drug formulary on request.
20. Members have the right to access minor consent services.
21. Members have the freedom to exercise these rights without negatively affecting how they are treated by Molina Dual Options program staff, its providers, consistent with CMS and regulations for those states that are participating in the MMP demonstration plan. There are disciplinary procedures for staff members who violate this policy.
22. Members have a right to make recommendations regarding the organization's member rights and responsibilities policies.
23. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
24. Members have the right to file a grievance or complaint if they believe their linguistic needs were not met by the plan.
25. Members have the right to receive instructions on how they can view online, or request a copy of Molina Dual Options program non-proprietary clinical and administrative policies and procedures.
26. Female members should be able to go to a women's health provider on Molina Dual Options panel for covered Women's health services.
27. Molina Dual Options program's staff and its providers will not discriminate against enrollees due to Medical condition (including physical and mental illness) or for any of the following: claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.
28. Members have the right to contact the United States Department of Health and Human Services Office of Civil Rights and/or their local office for Civil Rights with any complaints of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services.
29. Members have the right to reasonable accommodation in order to access care.

B. In addition, Molina Dual Options members have the right to:

1. Request a State Fair Hearing by calling 1-800-952-5253. Members also have the right to receive information on the reason for which an expedited State Fair Hearing is possible.
2. Receive family planning services, treatment for any sexually transmitted disease, emergency care services, from Federally Qualified Health Centers and/or Indian Health Services without receiving prior approval and authorization from Molina Healthcare.

B. Molina Dual Options Plan Members have a responsibility to:

1. Members have the responsibility to be familiar with and ask questions about their health benefits. If Members have a question about their benefits, they may call Molina Dual Options Member Services Department.
2. Members have the responsibility to provide information to their doctor or Molina Dual Options staff that is needed to care for them.
3. Members have the responsibility to be active in decisions about their health care.
4. Members have the responsibility to understand their health conditions and work with their provider to develop treatment goals and follow the care plans and instructions for care that they have agreed on with their doctor(s).
5. Members have the responsibility to build and keep a strong patient-doctor relationship. Members have the responsibility to cooperate with their doctor and staff. This includes being on time for their visits or calling their doctor if they need to cancel or reschedule an appointment. Members are expected to call their provider 24 hours in advance if they are going to be late or cannot keep their appointment.
6. Members have the responsibility to present their Molina Dual Options ID and State card when receiving medical care and report any fraud or wrongdoing to or the proper authorities. In addition, not let anyone else uses their Healthcare ID card.
7. Members have a responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
8. Call - Molina Dual Options staff within 24 hours of a visit to the emergency department or an unexpected stay in the hospital.
9. Inform - Molina Dual Options staff if they would like to change their PCP and - Molina Dual Options will verify that the PCP selected is contracted with - Molina Dual Options program and is accepting new patients
10. Inform - Molina Dual Options staff and their county case worker in case of change of name address or telephone number or if there are any changes that could affect their eligibility.
11. Let - Molina Dual Options staff and your health care provider know if they or any of their family members have other health insurance coverage.

In addition, - Molina Dual Options have the responsibility to: **Inform the Member Services Department of any change of address or any changes to entitlement that could affect continued eligibility.**

XI. Provider Responsibilities

D. 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's Dual Options product which covers the member and the requirements of any applicable government-sponsored program.

E. 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.

F. 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.

G. Referrals

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.

H. Contracted Providers

Except in the case of emergency services or after receiving prior authorization of 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 Dual Options Plan.

I. Member Eligibility Verification

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

J. Admissions

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

K. 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.

L. 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.

M. 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 Chapter VI – Quality Improvement, taking into account the urgency of the need for the services.

N. 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.

O. 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.

P. 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.

Q. Confidentiality of Member Health Information

Providers are expected to comply with all applicable state and federal laws. Refer to Chapter VII for HIPAA requirements and information.

R. HIPAA Transactions

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

S. National Provider Identifier (NPI)

Providers are expected to comply with all HIPAA NPI regulations. Refer to **Chapter VII - HIPAA** requirements and information.

T. 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](#), for guidance.

U. Member Access to Health Information

Providers are expected to comply with all applicable state and federal laws. Refer to Chapter VII for HIPAA requirements and information.

V. Participation in Grievance Program

Providers are expected to participate in Molina Dual Option's 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 Chapter XIV regarding members' appeals and grievances.

W. 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.

X. 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, and Interdisciplinary Care Teams (ICTs). Providers will also cooperate with Molina Healthcare in audits to identify, confirm, and/or assess utilization levels of covered services.

Y. 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.

Z. 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

AA. 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.

BB. 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. A complete list of Provider education is as follows:

- New Provider Orientation
- Cultural Competency
- Sensitivity Training
- Clear Coverage
- Web-Portal
- Continuing Medical Education (CME)

CC. 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 will cooperate with Molina and comply with the DHCS Managed Care Health Plan Marketing 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>

XII. Claims and Compensation

When billing for services rendered to Molina Dual Options Plan members, providers must bill with the most current Medicare approved coding (ICD-9, ICD-10 CPT, HCPCS, etc.) available. Claims must be submitted using the proper claim form/format and/or appropriate billing documents e.g., for paper claims a CMS1500 or UB04, invoice, etc. 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 and Medicare fee-for-service. The following information must be included on every claim:

A. Data Elements Required

- Member name, date of birth and Molina Medicare member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid ICD-9 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) or applicable identifier.
- 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 Dual Options will process only legible Dual Options Plan claims. Handwritten claims are not acceptable and will be rejected. Incomplete, inaccurate, or untimely re-submissions may result in denial of the claim.

It is highly recommended that claims be submitted electronically in the approved ANSI X12 5010 format. However, if paper claims must be submitted, please submit paper claims and all supporting documentation to Molina Dual Options office at the following address:

Molina Dual Options Claims
PO Box 22712
Long Beach, CA 90801

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 Medicare 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 Dual Options is concerned that all provider questions and concerns about claims are answered timely. Please refer to contact information below.

Mailing Address:
Molina Healthcare of Ohio
Molina Dual Options Claims
PO Box 22712
Long Beach, CA 90801

Physical Address for overnight packages:
Molina Healthcare of Ohio
Molina Dual Options Plan
3000 Corporate Exchange Dr.
Columbus, OH 43231

D. Electronic Claim Submissions

Molina Healthcare, Inc. 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 Ohio Payer ID number – 20149 – when submitting claims electronically.**

Molina Healthcare, Inc. 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 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 Dual Options members must be filed within one hundred and eighty (120) calendar days from 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 for Molina Dual Options 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) and ODJFS.

- In accordance with 42 C.F.R. § 447.46, the ICDS Plan must pay ninety percent (90%) of all submitted Clean Claims within thirty (30) days of the date of receipt and ninety-nine percent (99%) of such claims within ninety (90) days of the date of receipt.
- The clean pharmacy and non-pharmacy claims will be separately measured against the thirty (30) and ninety (90) day prompt pay standards. The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by the ICDS Plan and delegated claims processing entities.

G. Billing Options/ Molina Members

- The provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a member be liable to the provider for any sums owed by Molina MyCare to the provider. Provider agrees to accept payment from Molina MyCare as payment in full.

A provider may bill a Molina MyCare member only for *non-covered* services OR those services determined not to be medically necessary by Molina Healthcare's Utilization Management Department if both the member and the provider sign a payment agreement prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

- The service is not covered by ODM or Molina Healthcare OR services determined not to be medically necessary by Molina Healthcare's Utilization Management Department.
- The member is choosing to receive the service and agrees to pay for it, even though the service may have been determined by Molina Healthcare to be not medically necessary.
- The member is under no obligation to pay the provider if the service is later found to be a covered benefit, even if the provider is not paid because of non-compliance with Molina Healthcare's billing and/or prior authorization requirements.
- For members with limited English proficiency, the agreement must be translated or interpreted into the member's primary language to be valid and enforceable. This interpretation/translation service is the responsibility of the provider to supply.

Please note billing members for missed appointments is prohibited.

H. Provider Claim Reconsideration

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

- Requests must be clear and concise and explain the reason for reconsideration
- 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 reconsideration should be faxed to 800-499-3406

Claim Corrections

Providers seeking a correction or reprocessing of a previously adjudicated claim must request such action within 120 days of the original remittance advice unless otherwise stated in the provider contract. Requests for correction of a claim submitted after the 120 day period or the timeframe specified in the provider contract cannot be considered.

CMS 1500

The request for correction to a CMS 1500 claim form must include a Molina Healthcare Corrected Claim Form or a cover letter clearly explaining the reason for the correction. Forms are available at <http://www.MolinaHealthcare.com>. Select For Health Care Professionals, Forms, Provider Forms. Requests for claim corrections should be mailed to:

Molina Healthcare of Ohio, Inc.
MyCare Ohio Plan
PO Box 22712
Long Beach, CA 90801

UB 04/CMS 1450

The request for correction to a UB 04 claim form can be submitted by paper or electronically and must include the correct bill type of xx7.

I. Overpayments and Refund Requests

In the event Molina Dual Options MyCare Ohio determines that a claim has been overpaid, is a duplicate payment or that funds were paid which were not provided for under the providers contract, the overpayment amount will be automatically recovered by way of offset or recoupment unless the provider contract states otherwise. All recovery activity will appear on your Remittance Advice.

Use the Return of Overpayment Form to submit unsolicited refunds or check returns. Go to <http://www.MolinaHealthcare.com>. . Select For Health Care Professionals; Forms; Provider Forms; Return of Overpayment.

If you have any questions regarding a refund, please call the Claims Recovery Unit at 1-866-642-8999 and follow the prompts to Ohio or Molina Healthcare Provider Services at 1-800-642-4168.

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

Molina Healthcare is required to notify Ohio Department of Medicaid (ODM) and/or its designated agent within fourteen calendar days of all requests for the release of financial and medical records to a member or representative pursuant to the filing of a tort action.

Molina Healthcare must submit a summary of financial information to ODM and/or its designated agent within thirty calendar days of receiving an original authorization to release financial claim statement letter from ODM pursuant to a tort action. Upon request, Molina Healthcare must provide ODM and/or its designated agent with true copies of medical claims.

Molina Healthcare is prohibited from accepting any settlement, compromise, judgment, award or attempt to recover any third party resources available to members and shall maintain records pertaining to TPL collections on behalf of members for audit and review.

J. Claims Review and Audit

Providers acknowledge Molina Dual Options MyCare Ohio's right to review each provider's claims prior to payment for appropriateness in accordance with industry standard billing rules. Molina Healthcare has a business arrangement with Verisk Health (formerly HealthCare Insight/ HCI) for the screening and reviewing of professional and outpatient facility claims. Molina Healthcare has a claims pre-payment auditing process that identifies frequent correct coding billing errors such as:

- Bundling and unbundling coding errors
- Duplicate claims
- Services included in global care
- Incorrect coding of services rendered

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

XIII. Fraud, Waste and Abuse Program

A. Introduction

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

B. Mission Statement

Molina Healthcare of Ohio regards health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina Healthcare of Ohio has therefore implemented a program to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

C. Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. Government for payment.

The term “knowing” is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

D. Deficit Reduction Act

On February 8, 2006, the Deficit Reduction Act (“DRA”) was signed into law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare of Ohio who receive or pay out at least \$5 million in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina Healthcare of Ohio, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

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

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

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

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

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

E. Definitions

Fraud:

“Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

Waste:

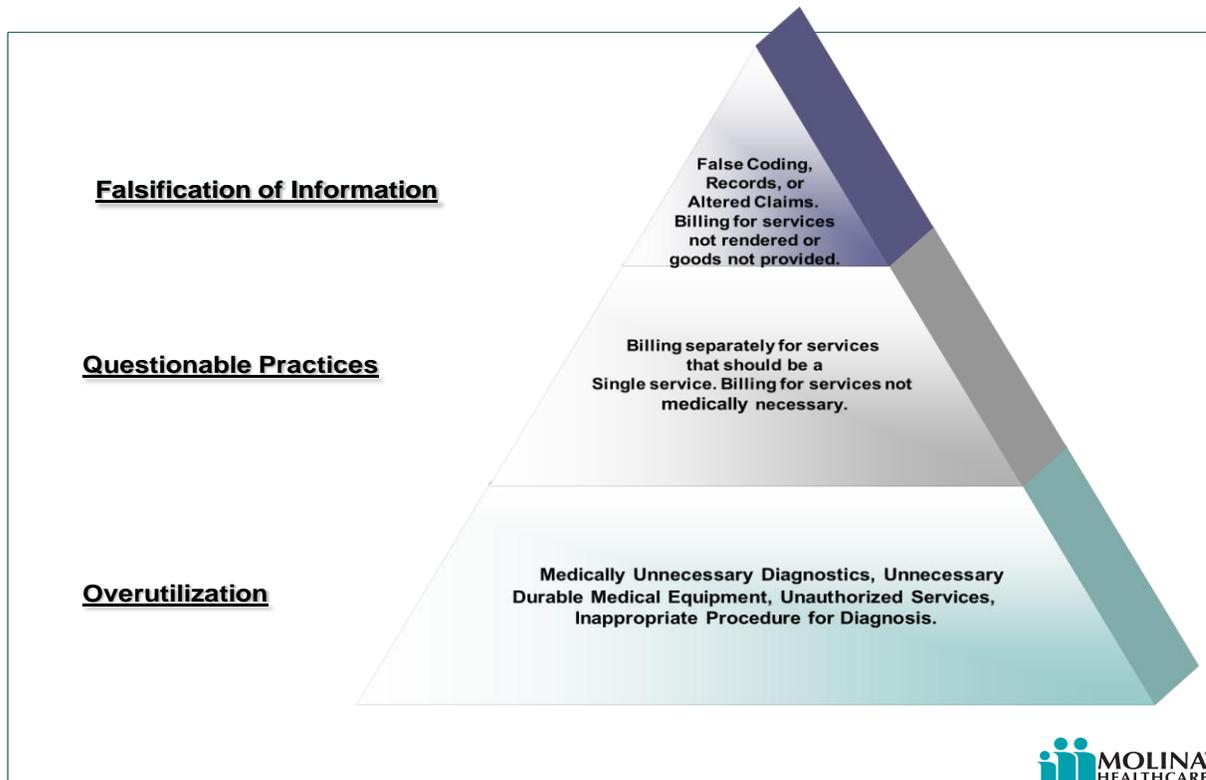
Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.

Abuse:

“Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

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

- Billing for services, procedures and/or supplies that have not actually been rendered.
- Providing services to patients that are not medically necessary.
- Balance Billing a Medicaid member for Medicaid covered services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider’s usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, “unbundling” of procedures, non-covered treatments to receive payment, “up-coding”, and billing for services not provided.
- Concealing patients misuse of Molina Healthcare of Ohio identification card.
- Failure to report a patient’s forgery/alteration of a prescription.
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients.
- A physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)



G. Review of Provider

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

- Federal and State Medicaid sanction reports.
- Federal and state lists of excluded individuals and entities including the Ohio Office of Inspector General’s exclusion list.
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Medicaid suspended and ineligible provider list.
- Monthly review of state Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate government entity. Upon receiving this information the documents are presented to the Credentialing Committee for review and potential action.

The Credentialing staff will also present the list of physicians found on the Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

H. Provider/Practitioner Education

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

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

I. Review of Provider Claims and Claims System

Molina Healthcare Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance Department.

The claims payment system utilizes system edits and flags to validate those elements of claims are billed in accordance with standardized billing practices; ensure that claims are processed accurately and ensure that payments reflect the service performed as authorized.

Molina Healthcare of Ohio performs auditing to ensure the accuracy of data input into the claims system. The claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected and a thorough review of system edits is conducted to detect and locate the source of the errors.

J. Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Healthcare Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina Healthcare AlertLine can be reached toll free at 1-866-606-3889 or you may use the service's website to make a report at any time at <https://molinahealthcare.alertline.com>

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

Molina Healthcare of Ohio
Attn: Compliance
3000 Corporate Exchange Drive
Columbus, Ohio 43231

Remember to include the following information when reporting:

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

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

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

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

XIV. Credentialing and Recredentialing

The purpose of the Credentialing Program is to strive to assure that the Molina Healthcare, Inc. and its subsidiaries (Molina) network consists of quality practitioners who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community.

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

The Credentialing Program has been developed in accordance with state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The Credentialing Program is reviewed annually and revised and updated as needed.

A. Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the Molina network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. To remain eligible for participation practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

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

1. Practitioner must practice, or plan to practice within 90 calendar days, within the area served by Molina.
2. Practitioner must have a current, valid license to practice in their specialty in every state in which they will provide care for Molina members.
3. Practitioner must have current professional malpractice liability coverage with limits that meet Molina criteria.

4. If applicable to the specialty, practitioner must have a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration.
5. Dentists, Oral Surgeons, Physicians (MDs, DOs) and Podiatrists will only be credentialed in an area of practice in which they have adequate training as outlined below. Therefore, they must confine their practice to their credentialed area of practice when providing service to Molina members. Adequate training must be demonstrated by one of the following:
 - a. Current Board Certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association in the credentialed area of practice, the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM), or the American Board of Oral and Maxillofacial Surgery
 - b. Successful completion of a training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians in 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).
 - c. Practitioners (MD/DO) who are not Board Certified as described in section 5a above and have not completed an accredited Residency program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible as a General Practitioner, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.
6. At the time of initial application, the practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body.². This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.

² 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.

7. Practitioner must not be currently excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs.
8. Practitioner 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.
9. Physician Assistants and Nurse Practitioners, who are not licensed to practice independently but are required to be credentialed, 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.
10. Physicians (MD/DO), Primary Care Practitioners, Midwives, Oral Surgeons, Podiatrists and/or those practitioners dictated by state law, must have admitting privileges in their specialty or have a plan for hospital admission by using a Hospital Inpatient Team or having an arrangement with a credentialed Molina participating practitioner that has the ability to admit Molina patients to a hospital. Practitioners 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, Urgent Care and Wound Management do not require admitting privileges.
11. Licensed midwives who perform deliveries outside of an acute care hospital must have a formal arrangement in place with an OB/GYN contracted and credentialed with Molina Healthcare. This arrangement must include 24-hour coverage and inpatient care for Molina members in the event of emergent situations. Family Practitioners providing obstetric care may provide the back-up in rural areas that do not have an OB/Gyn. This back-up physician must be located within 30 minutes from the midwives practice.
12. Nurse Midwives, Licensed Midwives, Oral Surgeons, Physicians, Primary Care Practitioners and Podiatrists must have a plan for shared call coverage that includes 24-hours a day, seven days per week and 365 days per year. The covering practitioner(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. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Sleep Medicine, Sports Medicine, Urgent Care and Wound Management are not required to have 24-hour coverage.
13. Molina may determine, in its sole discretion, that a practitioner is not eligible to apply for network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina, who is currently in the Fair Hearing Process, or who is under investigation by Molina. Molina also may determine, in its sole discretion that a practitioner cannot continue network participation if the

practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina. For purposes of these criteria, a company is “owned” by a practitioner when the practitioner has a majority financial interest in the company, through shares or other means.

14. Practitioners denied by the Credentialing Committee are not eligible to reapply until one year after the date of denial by the Credentialing Committee. At the time of reapplication, practitioner must meet all criteria for participation outlined above.
15. Practitioners terminated by the Credentialing Committee are not eligible to reapply until five years after the date of termination by the Credentialing Committee. At the time of reapplication, practitioner must meet all criteria for participation as outlined above.
16. Practitioners denied or terminated administratively are eligible to reapply for participation anytime as long as the practitioner meets all criteria for participation above.

B. Burden of Proof

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

C. Practitioner termination and reinstatement

If a practitioner’s contract is terminated and later it is determined to reinstate the practitioner, the practitioner must be initially credentialed prior to reinstatement if there is a break in service more than 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 practitioner’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 30 calendar days, the practitioner can be reinstated without being initially credentialed.

If Molina is unable to recredential a practitioner within 36-months because the practitioner is on active military assignment, maternity leave or sabbatical; but the contract between Molina and the practitioner remains in place, Molina will recredential the practitioner upon his or her

return. Molina will document the reason for the delay in the practitioner's file. At a minimum, Molina will verify that a practitioner who returns has a valid license to practice before he or she can resume seeing patients. Within 60 calendar days of notice when the practitioner resumes practice, Molina will complete the recredentialing cycle. If either party terminates the contract and there is a break in service of more than 30 calendar days, Molina will initially credential the practitioner before the practitioner rejoins the network.

When a practitioner has a direct contract with Molina and is also credentialed by and under contract with an entity Molina has delegated credentialing to, Molina does not need to credential the provider. The credentialing done by the delegated entity applies to the practitioner for any location in which they are working.

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

D. Credentialing Application

At the time of initial credentialing and recredentialing, the practitioner must complete a credentialing application designed to provide Molina with information necessary to perform a comprehensive review of the practitioner's credentials. The application must be completed in its entirety. The practitioner must attest that their application is complete and correct within 120 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 may use another organization's application as long as it meets all the factors outlined in this policy. Molina will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. The attestation 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. Practitioners may use language other than "drug" to attest they are not presently using illegal substances. Molina may accept more general or extensive language to query practitioners 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 practitioner 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 practitioner's current malpractice insurance. Molina may obtain a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the application.

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

Correctness and completeness of the application - Practitioners 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 is used, it must include an attestation to the correctness and completeness of the application. Molina does not consider the associated attestation elements as present if the practitioner did not attest to the application within the required time frame of 180 days. If state regulations require Molina to use a credentialing application that does not contain an attestation, Molina must attach an addendum to the application for attestation.

Meeting Application time limits - If the practitioner attestation exceeds 180 days before the credentialing decision, the practitioner 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 practitioner to update the attestation.

E. Office Site and Medical Record Keeping Practices Review

A review of office sites where you see Molina 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.

F. The Process for Making Credentialing Decisions

All practitioners requesting initial participation with Molina must complete a credentialing application. To be eligible to submit an application, practitioners must meet all the criteria outlined above in the section titled “Criteria for Participation in the Molina Network”. Practitioners may not provide care to Molina members until the final decision is rendered by the Credentialing Committee or the Molina Medical Director.

Molina recredentials its practitioners at least every thirty-six (36) months. Approximately six months prior to the recredentialing due date, a request will be sent to the practitioner requesting completion of a recredentialing application.

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

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

Once the application is received, Molina will complete all the verifications as outlined in the Credentialing Program Policy. In order for the application to be deemed complete, the practitioner must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina 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 must be provided.

If the practitioner does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina will discontinue processing of the application. This will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide proof of meeting 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 specific Credentialing Review 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 Credentialing

Committee. The Medical Director has the right to request the Credentialing Committee review any credentials file. The Credentialing Committee has the right to request to review any credentials file.

G. Credentialing Committee

Molina maintains a Credentialing Committee made up of other practitioners practicing in the community who make recommendations regarding credentialing decision using a peer review process. Once a credentials file contains all the necessary information it will be submitted for approval to the Credentialing Committee. If the Credentialing Committee determines further information is necessary to evaluate a provider's application, the Credentialing Department will request such information on behalf of the Credentialing Committee. Molina works with the Credentialing Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to Molina members.

A practitioner may not provide care to Molina members until the final decision from the Credentialing Committee or in situations of "clean files" the final decision from the Molina Medical Director.

The Governing Board of Molina has delegated the authority to approve and to deny applicants to the Credentialing Committee. The Credentialing Committee is required to meet no less than quarterly, but generally meets on a monthly basis, to facilitate timely processing of applicant files.

H. Delegating Credentialing and Recredentialing

Molina will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA), Provider Groups and other delegated entities that meet Molina's requirements for delegation. Molina'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's requirements.

Molina's Credentialing Committee retains the right to approve new providers and provider sites and terminate practitioners, providers and sites of care based on requirements in Molina Credentialing Policy.

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

- Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass Molina'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 90%.
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina at pre-assessment
- Agree to Molina's contract terms and conditions for credentialing delegates

- Submit timely and complete reports to Molina 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 areas of accreditation.

I. Non-Discrimination

Molina 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 practitioner specializes. This does not preclude Molina from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

Molina agrees that in the performance of this Provider Agreement or in the hiring of any employees for the performance of services under this Provider Agreement, Molina shall not by reason of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry, discriminate against any individual in the employment of an individual who is qualified and available to perform the services to which the Provider Agreement relates.

Molina agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the Provider Agreement on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry.

Prevention - Molina takes appropriate steps to protect against discrimination occurring in the credentialing and recredentialing processes.

Molina maintains a heterogeneous credentialing committee membership. It is also required that each committee member sign an affirmative statement annually to make decisions in a nondiscriminatory manner.

Monitoring - Every six months, Molina pulls credentialing data to show all credentialing decisions made and looks at a breakdown of types of decisions by provider's gender and age. This data is compiled into a report and presented to the Compliance Committee. The Compliance Committee reviews the report to ensure there are no obvious trends in discrimination when making credentialing decisions. Molina does not ask for providers' race or ethnicity in the credentialing process so this information is unknown when decisions are made.

If Molina receives any complaint regarding alleged discrimination, the complaint is thoroughly investigated and the results of the investigation are forwarded to the Molina legal department for review and determination.

J. Notification of Discrepancies in Credentialing Information

Molina will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license; malpractice claims history or sanctions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law. Please also refer to the section below titled Practitioners Right to Correct Erroneous Information.

K. Notification of Credentialing Decisions

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

L. Confidentiality and Immunity

Information regarding any practitioner 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 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 perform 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 practitioner'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 practitioner's or provider's provision of patient care services.

By providing patient care services at Molina, a practitioner or provider:

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the practitioner's or 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 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 or Practitioner;
2. Actions reducing, suspending, terminating or revoking a practitioner's and 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 operations and actions relating to practitioner and provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a practitioner or 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 practitioner or 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 practitioner or 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.

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. Each person is given a unique user ID and password. It is the strict policy of Molina 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-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 Staff is instructed not to divulge passwords to their co-workers.

M. Providers' Rights during the Credentialing Process

1. Providers have the right to review their credentialing file.

Providers have the right to review their credentialing file at any time. 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 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 are the application, the license and 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 (e.g., National Provider Data Bank, State Licensing Board), and verification of hospital privileges letters.

2. Providers have the right to correct erroneous information.

- Molina Healthcare will notify the provider if information is received during the credentialing process that
- conflicts with information given by the provider. Examples of these errors include, but are not limited to,

actions on a license, malpractice claims history, or board certification decisions. The credentialing/recredentialing process cannot be completed until the erroneous information is corrected and received by Molina Healthcare.

3. Providers' right to be informed of their application status.

Practitioners have a right, upon request, to be informed of the status of their application. Practitioners applying for initial participation are sent a letter when their application is received by Molina and are notified of their right to be informed of the status of their application in this letter. Practitioners are also notified of their right in the Provider Manual sent to them at the time of initial contracting.

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

N. Ongoing Monitoring Between Credentialing Cycles

Molina monitors for complaints, sanctions, adverse actions, disciplinary actions and malpractice cases between credentialing cycles for all practitioner types. When new information is received between recredentialing cycles, the practitioner will be immediately placed into the full credentialing process and will be recredentialled early. The practitioner must provide all necessary information to complete the recredentialing process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination. Molina takes appropriate action against practitioners when occurrences of poor quality are identified.

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

P. Providers opting out of Medicare

If a provider opts out of Medicare, that provider may not accept Federal reimbursement for a period of two (2) years. Providers who are currently opted out of Medicare are not eligible to contract with Molina for the Medicare line of business.

Q. Credentialing Committee Range of Actions, Notification to Authorities and Practitioner Appeal Rights

Molina uses established criteria in the review of practitioners' 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 Credentialing Committee can take one of the following actions against practitioners 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 practitioner 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 practitioners who are contracted by Molina. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. The purpose of this policy is to provide a mechanism for implementation of monitoring on watch status, requiring formal corrective action, suspension or termination of Molina practitioners.

If at any point a practitioner 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 practitioner 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 practitioner from the Molina network include, but are not limited to, the following:

1. The practitioner'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. Practitioner 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 practitioner's acts, omissions or conduct.
3. Practitioner 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 practitioner to Molina members.
4. Practitioner 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. Practitioner 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 practitioner has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the practitioner 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 practitioner's practice.
6. Practitioner 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. Practitioner 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. Practitioner'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. Practitioner has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.

10. Practitioner 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 practitioner's professional conduct or the health, safety or welfare of Molina members
11. Practitioner has or has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.
12. Practitioner 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 members.
13. Practitioner has not complied with Molina's quality assurance program.
14. Practitioner is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
15. Practitioner has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Practitioner makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
17. Practitioner has ever rendered services outside the scope of their license.
18. Practitioner 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. Practitioner's has or has ever failed to comply with the Molina Medical Record Review Guidelines.
20. Practitioner has or has ever failed to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring on a Committee Watch Status

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

When a practitioner 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 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 determination.

Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, Molina may work with the practitioner 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 months)

Within ten (10) calendar days of the Credentialing Committee's decision to place practitioner on a corrective action plan, the practitioner 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 practitioner'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 practitioner continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate practitioner response to corrective action will be brought to the Credentialing Committee for review and decision.

Summary Suspension

In cases where the Medical Director becomes aware of circumstances that pose an immediate risk to patients, a meeting will be held immediately with Molina Legal Counsel, the Medical Director and the Director of Credentialing. After discussing the facts, the practitioner 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 practitioner of the suspension, via a 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 practitioner
- The length of the suspension
- The estimated timeline for determining whether or not to reinstate or terminate the practitioner
- Details regarding the practitioner's right to request a fair hearing within 30 calendar days of receipt of the notice and their right to be represented by an attorney or another person of their choice.

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 practitioner's continued participation, discontinue the suspension or terminate the practitioner.

Termination

After review of appropriate information, the Credentialing Committee may determine that the practitioner 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 practitioner.

Within five working days after the Credentialing Committee makes a recommendation to terminate a practitioner, the Medical Director, Molina Legal Counsel and the Corporate Credentialing Director will meet to review the details regarding the Credentialing Committee's decision to terminate the practitioner and to draft the written notification to the practitioner.

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 practitioner will not be reported to the NPDB/HIPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the practitioner is sent a written notice of termination via certified mail, from the Medical Director, which includes the following:

- A Description of the action being taken
- Reason for termination
- Obligations of the practitioner regarding further care of Molina patients/members

Terminations based on unprofessional conduct or quality of care

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

Within ten (10) calendar days of the Committee's decision, the practitioner is sent a written notice of Molina'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 practitioner's right to request a fair hearing within 30 calendar days of receipt of notice (see Fair Hearing Plan policy). The Fair Hearing Policy explains that Molina will appoint a hearing officer and a panel of individuals to review the appeal.
- The practitioner does not request a fair hearing within the 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.
- Practitioner's right to be represented by an attorney or another person of their choice.
- Obligations of the practitioner regarding further care of Molina patients/members
- The action will be reported to the NPDB/HIPDB and the State Licensing Board.

Molina will wait 30 calendar days from the date the terminated practitioner received the notice of termination. If the practitioner requests a fair hearing within that required timeframe, Molina will follow the Fair Hearing Plan Policy. Once the hearing process is completed, the practitioner 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 and or HIPDB as defined in reporting to appropriate authorities section below. If the hearing committee overturns the termination decision and the practitioner remains in the Molina network, the action will not be reportable to the State Licensing Board or to the NPDB and or HIPDB.

If the practitioner does not request a hearing within the 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 practitioner and the termination will be reported to the State Licensing Board and the NPDB and or HIPDB as defined in reporting to appropriate authorities section below.

Notification to Authorities

Within 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) and Healthcare Integrity and Protection Data Bank (HIPDB)

R. Fair Hearing Plan Policy

Molina Healthcare, Inc., and its affiliates (“Molina”), will maintain and communicate the process providing procedural rights to Providers when a final action by Molina will result in a report to the State Licensing Board, NPDB, and/or HIPDB.

1. Definitions

- a) Adverse Action shall mean an action that entitles a Provider to a hearing, as set forth in Section B (1)-(3) below.
- b) Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina affiliate state plan wherein the Provider is contracted.
- c) 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.
- d) Medical Director shall mean the Medical Director for the respective Molina affiliate state plan wherein the Provider is contracted.
- e) Molina Plan shall mean the respective Molina affiliate state plan wherein the Provider is contracted.
- f) Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.
- g) Peer Review Committee or Credentialing Committee shall mean a Molina Plan committee or the designee of such a committee.
- h) Plan President shall mean the Plan President for the respective Molina affiliate state plan wherein the Provider is contracted.
- i) Provider shall mean physicians, dentists, and other health care practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).
- j) State shall mean Molina Healthcare of Washington, Inc.
- k) State Licensing Board shall mean the state agency responsible for the licensure of Provider.
- l) Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a Provider’s competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider’s contract with a Molina Plan.

m) Medical Disciplinary Cause or Reason shall mean the aspect of a provider's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

2. 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:

- a)** Revocation, termination of, or expulsion from Molina Provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board, NPDB, and/or HIPDB.
- b)** Suspension, reduction, limitation, or revocation of authority to provide care to Molina members.
- c)** Any other final action by Molina that by its nature is reportable to the State Licensing Board, NPDB, and/or HIPDB.
 - i. A provider's application is denied or rejected for a medical disciplinary cause or reason
 - ii. A provider's agreement is terminated or revoked for a medical disciplinary cause or reason
 - iii. Restrictions are imposed, or voluntarily accepted on the Provider's agreement for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
 - iv. If a provider takes any action listed below, after receiving notice of a pending investigation(s) initiated for a medical disciplinary cause or reason or after receiving notice that their application is denied or will be denied for a medical disciplinary cause or reason an 805 Report shall be filed within 15 days after the licentiate takes any of the following actions:
 - a. Resigns or takes a leave of absence
 - b. Withdraws or abandons his or her application
 - c. Withdraws or abandons the request for reapplication

3. 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:

- a)** State the reasons for the action;
- b)** State any Credentialing Policy provisions that have been violated;

- c) Advise the Provider that he/she has the right to request a hearing on the proposed Adverse Action;
 - d) 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 Plan Medical Director by certified mail, return receipt requested, or personal delivery;
 - e) Advise the Provider that he/she has the right to be represented by an attorney or another person of their choice.
 - f) 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;
 - g) State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal law; and
 - h) Provide a summary of the Provider's hearing rights or attach a copy of this Policy.
4. 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.

5. Appointment of a Hearing Committee

- a)** 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.
- b)** 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.
- c)** Responsibilities - The Hearing Committee shall:
 - i. Evaluate evidence and testimony presented.
 - ii. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.
 - iii. Maintain the privacy of the hearing unless the law provides to the contrary.
- d)** 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.
- e)** Disclosure and Challenge Procedures – Any person appointed to the Hearing Committee shall disclose to the Chief Medical Office/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 Office believes that the person is unable to render an impartial decision.

6. Hearing Officer

- a)** 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.
- b)** Scope of Authority - The Hearing Officer shall have the sole discretion and authority to:
 - i. Exclude any witness, other than a party or other essential person.

- ii. Determine the attendance of any person other than the parties and their counsel and representatives.
- iii. 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.

c) Responsibilities - The Hearing Officer shall:

- i. 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;
- ii. Ensure that proper decorum is maintained;
- iii. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;
- iv. Issue rulings pertaining to matters of law, procedure and the admissibility of evidence;
- v. Issue rulings on any objections or evidentiary matters;
- vi. Discretion to limit the amount of time;
- vii. Assure that each witness is sworn in by the court reporter;
- viii. May ask questions of the witnesses (but must remain neutral/impartial);
- ix. May meet in private with the panel members to discuss the conduct of the hearing;
- x. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;
- xi. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and
- xii. Prepare the written report.

7. 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.

8. Notice of Hearing

The Notice of Hearing shall contain and provide the affected Provider with the following:

- a) The date, time and location of the hearing.

- b) The name of the Hearing Officer.
- c) The names of the Hearing Committee Members.
- d) 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.
- e) 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.
- f) 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.

9. Pre-Hearing Procedures

- a) The Provider shall have the following pre-hearing rights:
 - i. 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
 - ii. 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.

- b) The Hearing Committee shall have the following pre-hearing right:

To inspect and copy, at Molina'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.

- c) 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:
 - i. Whether the information sought may be introduced to support or defend the charges;
 - ii. The exculpatory or inculpatory nature of the information sought, if any;
 - iii. The burden attendant upon the party in possession of the information sought if access is granted; and
 - iv. Any previous requests for access to information submitted or resisted by the parties.
- d) 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.
- e) 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.
- f) 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.
- g) 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.

10. Conduct of Hearing

- a) 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:
 - i. Call and examine witnesses for relevant testimony.
 - ii. Introduce relevant exhibits or other documents.
 - iii. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
 - iv. Otherwise rebut evidence.
 - v. Have a record made of the proceedings.

- vi. Submit a written statement at the close of the hearing.
- vii. 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.

b) Course of the Hearing

- i. Each party may make an oral opening statement.
- ii. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.
- iii. The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.
- iv. 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.
- v. 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.

c) Use of Exhibits

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

d) Witnesses

- i. Witnesses for each party shall submit to questions or other examination.
- ii. 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.
- iii. 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.
- iv. The party producing such witnesses shall pay the expenses of their witnesses.

e) Rules for Hearing:

- i. Attendance at Hearings
- ii. 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.
- iii. Communication with Hearing Committee
- iv. 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.
- v. Interpreter
- vi. Any party wishing to utilize an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

11. 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:

- a) A summary of facts and circumstances giving rise to the hearing.
- b) A description of the hearing, including:
 - i. The panel members' names and specialties;
 - ii. The Hearing officer's name;
 - iii. The date of the hearing;
 - iv. The charges at issue; and
 - v. An overview of witnesses heard and evidence.
- c) The findings and recommendations of the Hearing Committee.
- d) 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.

12. Burden of Proof

The burden of proof during a hearing regarding the denial of an initial applicant shall be as follows:

Initial applicants shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications.

Initial applicants shall not be permitted to introduce information not produced upon request of the Peer Review Committee or Credentialing Committee during the application process; unless the initial applicant establishes that the information could not have been produced preciously in the exercise of reasonable diligence.

The burden of proof during all hearings other than the denial of an initial applicant shall be as follows:

The Peer Review Committee or Credentialing Committee recommending the Adverse Action shall bear the burden of persuading the Hearing Committee that its action or recommendation is reasonable and warranted. The burden of proof shall be by a preponderance of the evidence. 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.

13. 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.

14. 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, 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.

15. 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.

16. Postponements

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

17. 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.

18. 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.

19. 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 will submit a report to the State Licensing Board, NPDB, and/or HIPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

Reports to the State Licensing Board, NPDB, and/or HIPDB for adverse actions must be submitted within 15 days from the date the adverse action was taken.

20. 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.

21. Confidentiality and Immunity

Information regarding any practitioner 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 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 perform 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 practitioner’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 practitioner’s or provider’s provision of patient care services.

By providing patient care services at Molina, a practitioner or provider:

- a) Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the practitioner’s or provider’s qualifications.
- b) 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.
- c) Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina 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:

- A. Any type of application or reapplication received by the Provider or Practitioner;
- B. Actions reducing, suspending, terminating or revoking a practitioner’s and provider’s status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
- C. Hearing and appellate review;
- D. Peer review and utilization and quality management activities;
- E. Risk management activities and claims review;
- F. Potential or actual liability exposure issues;
- G. Incident and/or investigative reports;
- H. Claims review;
- I. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
- J. Any activities related to monitoring the quality, appropriateness or safety of health care services;
- K. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
- L. Any Molina operations and actions relating to practitioner and provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a practitioner or 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 practitioner or 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 practitioner or 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.

XV. Member Grievances and Appeals

Appeals, Grievances, and State Hearings

Molina Healthcare maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased and appropriate resolutions. Molina Healthcare members, or their authorized representatives, have the right to voice a grievance or submit an appeal through a formal process.

Molina Healthcare ensures that members have access to the appeal process, by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner; including oral, written, and language assistance if needed. Grievance information is also included in the Member Handbook.

This section addresses the identification, review and resolution of member grievances and appeals.

MEMBER APPEALS AND GRIEVANCES

The Ohio Administrative Code (OAC) defines a grievance as an expression of dissatisfaction with any aspect of Molina Healthcare or participating providers' operations, provision of health care services, activities or behaviors.

Members may file a grievance by calling Molina Healthcare's Member Services Department at 1-855-665-4623 (TTY for the hearing impaired: 1-800-750-0750).

Members may also submit a grievance in writing to:

Molina Healthcare of Ohio, Inc.
Attn: Appeals and Grievance Department/MIRR
PO Box 349020
Columbus, Ohio 43234-9020

Members may authorize a designated representative to act on their behalf (hereafter referred to as "representative"). The representative can be a friend, a family member, health care provider, or an attorney. An authorized Representative Form can be found on Molina's member website.

Molina Healthcare will investigate, resolve and notify the member or representative of the findings. Every attempt will be made to resolve a grievance at the time of a call. However, if a grievance is unable to be resolved immediately, it will be resolved as expeditiously as possible, but no later than the following timeframes:

- Within twenty-four (24) hours if Grievance must be expedited for the following reasons:
 - The complaint involves Molina Healthcare's decision to invoke an extension relating to an organizational determination or reconsideration.
 - The complaint involves Molina Healthcare's refusal to grant and a member's request for an expedited organization determination or reconsideration.

- Two (2) working days of receipt of a grievance related to accessing medically necessary Medicaid covered services.
- Thirty (30) calendar days of receipt for grievances that are not regarding access to services.

If the grievance resolution affirms the denial, reduction, suspension, or termination of a Medicaid-covered service, or if the resolution permits the billing of a member due to Molina Healthcare's denial of payment for that service, Molina Healthcare will notify the member of their right to request a state hearing.

All grievances received will be kept confidential except as needed to resolve the issue and respond to the member or representative.

Appeals are the request for a review of an action. The member or their representative acting on their behalf has the right to appeal Molina Healthcare's decision to deny a service. For member appeals, Molina Healthcare must have written consent from the member authorizing someone else to represent them. A determination will not be made if written consent is not received within 15 calendar days from the date the appeal was received. An authorized Representative Form can be found on Molina's member website. An appeal can be filed verbally or in writing within 90 days from the date of the Notice of Action. Molina Healthcare will send a written acknowledgement in response to written appeal requests received. Molina Healthcare will respond to the member or representative in writing with a decision within 15 calendar days (unless an extension is granted to Molina Healthcare by ODM).

While lack of written consent does not pose any barrier to the commencement of the appeal process; if it is not received within the time frame, the appeal request will be closed and no determination will be made.

The member or their representative should state the reason they feel the service should be approved and be prepared to provide any additional information for review. For a copy of the Grievance and Appeal Form, see the "Forms" section of this manual.

Molina Healthcare has an expedited process for reviewing member appeals when the standard resolution timeframe could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function.

Expedited member appeals may be requested by the member or representative orally or in writing. Molina Healthcare will promptly inform the member or representative of the decision whether to expedite the appeal within 24 hours of receipt. With few exceptions, an expedited member appeal will be resolved as expeditiously as the member's health condition requires but will not 72 hours from receipt. If Molina Healthcare denies the request for an expedited resolution of an appeal, the appeal will be transferred to the standard resolution timeframe of 15 calendar days from the date the appeal was received. The member or representative will be notified of an expedited resolution within 72 hours of Molina Healthcare's receipt.

No punitive action will be taken against a member or representative for filing an expedited member appeal.

A member has the right to request a state hearing from the Bureau of State Hearings anytime there is dissatisfaction with Molina Healthcare's decision related to Medicaid services. It is not necessary for a member or representative to file an appeal prior to requesting a state hearing.

Members are notified of their right to a state hearing in all of the following situations:

- A service denial (in whole or in part)
- Reduction, suspension or termination of a previously authorized service
- A member is being billed by a provider due to a denial of payment and Molina Healthcare upholds the decision to deny payment to the provider

A health care provider may act as the member's authorized representative or as a witness for the member at the hearing.

Appeal decisions not wholly resolved in the member's favor will include information on how to request a state hearing and instructions on how to continue receiving benefits if benefits were denied until the time the state hearing is scheduled. If the state hearing upholds Molina Healthcare's decision and continued benefits were requested in the interim, the member may be responsible for payment.

XVI. 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) may request that the determination be appealed. A member, a member's representative, or provider, are the only parties who may request that Molina Medicare expedite a coverage determination or redetermination. The member's provider is prohibited from requesting a standard redetermination or higher appeal without being the member's appointed representative.

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 or provider) to serve as their personal representative to act on their behalf. After the date of the denial, a member has up to sixty (60) days to request a redetermination. This is the first level of appeal for Part D adverse decisions. Appeal data is confidential.

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

At any time during the appeal process, the member or personal representative may submit written comments, papers or other data about the appeal in person or in writing. If the appeal/reconsideration is denied, the member has the right to send the appeal to the Independent Review Entity (IRE) within sixty (60) days of receipt of the appeal. The IRE has seven (7) days to make a decision for a standard appeal/reconsideration and seventy-two (72) hours for an expedited request. The IRE will notify Molina Medicare 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 Medicare 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 Medicare'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 Medicare's compliance with determinations to decisions that fully or partially reverse an original Molina Medicare 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 Medicare is committed to providing access to medically necessary prescription drugs to Members of Molina Medicare. If a drug is prescribed that is not on Molina Medicare'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 Medicare'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 Medicare at (866) 472-4584 or fax (866) 450-3914**

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 Medicare 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 Medicare will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Molina Medicare network pharmacy and other plan rules are followed.

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

2. **Copayments for Part D** – Under the Molina Dual Options MyCare Ohio Program, the member does not have an out of pocket responsibility.
3. **Restrictions on Molina Medicare Drug Coverage**
Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:
 - **Prior Authorization:** Molina Medicare 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 Medicare may not cover the drug;
 - **Quantity Limits:** For certain drugs, Molina Medicare limits the amount of the drug that it will cover;
 - **Step Therapy:** In some cases, Molina Medicare 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 Medicare 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 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 Medicare's 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 Medicare Members with Medicaid coverage may have a limited selection of these excluded medications as part of its Medicaid coverage for Members assigned to Molina Medicaid.

5. **There may be differences between the Medicare and Medicaid Formularies.** The Molina Medicare Formulary includes many injectable drugs not typically found in its Medicaid formularies such as those for the aged, blind and disabled.
6. **Requesting a Molina Medicare Formulary Exception -** Molina 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 Medicare website www.MolinaMedicare.com.
7. **Requesting a Molina Medicare Formulary Redetermination (Appeal) -** The appeal process involves an adverse determination regarding Molina 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 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 Medicare 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 Medicare 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 redetermination 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 Medicare will honor this request.
- If a member submits an appeal without provider support, Molina Medicare 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 Medicare 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 Medicare 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) 472-4584**. Written appeals must be mailed or **faxed toll free (866) 450-3914**.

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

Molina Medicare will request submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by: 1) Molina Medicare Pharmacy Technician under the supervision of a pharmacist; 2) Molina Medicare Pharmacist; or, 3) Chief Medical Officer (CMO) of Molina Medicare. Review criteria will be made available at the request of the member or his/her prescribing provider. Molina Medicare 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 seven (7) CMS-required compendia for consideration. The submitted excerpts must site a favorable recommendation.
- c. Depending upon the prescribed medication, Molina Medicare 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 Medical Director of Molina Medicare. 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 Medicare denies coverage of the prescribed medication, Molina Medicare 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 Medicare 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 Medicare 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 Medicare does not give the member a written notification within the specified timeframe, Molina Medicare 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 Medicare'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 Medicare 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 Medicare 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 Medicare 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 Medicare to make a re-determination, Molina Medicare will request the necessary information within twenty-four (24) hours of the initial request for an expedited re-determination. Molina Medicare 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.

XVII. Web-Portal

Molina Dual Options Plan Providers may register on the Web Portal to verify member eligibility and benefits, search for service request/authorizations and claims 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, Inc. online. A new provider registration process that includes a how-to video guides providers on the E-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.
- **Claim Status Updates and Status Change Notifications** – The system provides real-time updates when viewing claims status information 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.
- **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 Medicare members and will receive notifications when they create a service request/authorization to determine if a patient/Molina Dual Options member previously received the service.
- **Member Eligibility** – Access to 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.

Creating a Claim in Web-Portal

There are three (3) sections in creating professional claims; **Member, Provider and Summary.**

Member	
Member Information	Enter insured member's information and patient information will automatically populate based on input. If patient is not same as insured subscriber, enter patient information. (e.g. newborn covered under mother)
Patient Condition	Enter dates that apply to patient condition as well as referring information and EPSDT claims. Include ambulance claims information, if applicable.
Verify Required Information	Requires that you enter place of service, patient account number, other health benefit plan (if known) and authorization to release patient information.
Other Insurance	Enter information for other insurance, if applicable.
Other Information	Enter other information such as Auto Accident, Employment, Other Party Responsible, etc., if known.
Provider	
Submitter Contact Information	Enter all required fields for submitter's contact information.
Billing Provider Information	The required information will automatically populate based on your account or the Billing Provider you selected from the drop down menu.
Rendering Provider Information	The required information will automatically populate based on your account or the Renderings Provider you selected from the drop down menu. If the rendering provider information is not available, call the Provider Services department for your state.
Facility Information	The required information will automatically populate based on your account or the Facility you selected from the drop down menu.
Diagnosis Code	Enter or search for a diagnosis code(s). You must enter at least one (1) diagnosis code.
Claim Line Details	Service From Date, Service To Date, Place of Service, Procedure Code, Units of Measurement, Quantity and Charges are required to add Claim Line Details. At least one Diagnosis Code reference is required for each claim line entered to submit your claim.
Supporting Information	This section is available for comments and remarks or brief explanatory statements. Comments are limited to 256 characters.
Summary Section	Summary section shows all input from the member and provider forms. You may review your inputs in this section before submitting the claim.

Open Incomplete Claim

Providers have the option to save an incomplete claim. To retrieve a claim take note of the Tracking Number found on top of the claim and open unsaved claim through **Claims Inquiry** page.

Export Claims Report Excel

The export claims report module allows you to download a report of claims submitted. Enter Service Dates From and Service Dates To, and then click **Submit**. Click **Search** and an Excel file will be generated and placed in the Download Exported Claims module.

Download Exported Claims File

After you have exported a claim file, click **Save** to download the file and open file in Excel.

XVIII. Risk Adjustment Management Program

A. Background

Risk Adjustment is a payment methodology designed to pay appropriate premiums for each Molina Dual Options member. CMS bases its premium payment according to the health status of each member – more reimbursement for sicker, less healthy members and less reimbursement for healthy members. Member health status is determined according to diagnosis codes submitted by Molina Healthcare, Inc. to CMS from claims data/encounters and other valid sources, i.e. medical record audits.

The data submitted to CMS is predictive of future medical expenses; the data collected in the current year determines the premium for the following year. The premium amount would cover the cost of any episodic acute care as well as progression into chronic conditions. In order to ensure that the premium Molina's Dual Options Plan receives actually covers the cost of care, it is necessary that Molina Healthcare, Inc. receives complete, accurate and comprehensive diagnostic data from providers and hospitals and that data is renewed for each reporting period.

The Molina Risk Adjustment Management Program (RAMP) helps to identify unreported or under reported conditions (known as “suspects”). RAMP utilizes systems, tools and vendor services to calculate the risk adjustment score, which is the accumulation of all the factors that go into calculating the premium payment amount. This score also allows identification of members according to their health status. Sick = higher number. Healthy = lower number. The health plan will use the identified suspects to perform chart audits to ensure that providers are submitting accurate diagnosis codes reflected in the medical record documentation. Additional and/or corrected data generated is submitted to CMS. CMS takes the data submitted from Molina Healthcare, Inc. that has been approved and calculates the premium. The premium factors consist of values for age, sex, Medicaid eligibility (poverty), disability, and the Hierarchical Condition Categories (HCCs). The total score, or Risk Adjustment Factor, is then multiplied by the rate book or the bid amount to obtain the total premium amount paid to Molina Healthcare, Inc..

- Every year there is an open enrollment period when beneficiaries may choose which health plan to join. Medicare plans compete by offering different benefit packages with different premiums.
- The Medicare plans submit bids to CMS each year, essentially saying that they can provide the enumerated benefits for a certain amount. When CMS accepts a bid, the plan is held to that premium amount. The amount they bid is directly dependent upon the revenue that they anticipate receiving from risk adjustment.
- Therefore, the accurate submission of data for risk adjustment is critical to the care of our Members.

B. Required Submissions

The Risk Adjustment Management Program at Molina is responsible for analyzing encounter data for Molina Members submitted by hospitals and other inpatient facilities, hospital outpatient facilities, physician groups, IPAs and other providers contracted with Molina's Dual Options Plan. This includes all subcontracted and sub-capitated providers to a capitated entity.

C. Data Submission Reporting

Molina currently contracts with Emdeon to capture encounter data and with Trizetto for submission to CMS. Emdeon accommodates claims data in either hard copy or electronic submission. The preferred media is electronic submission.

D. Diagnosis and Procedure Codes

Each diagnosis documented on the medical record must be coded to the highest level of specificity, following the current Official ICD-9 and ICD-10 Coding Guidelines and Risk Adjustment Guidelines from CMS.

Procedure codes and procedure modifiers are matched against the particular coding scheme used (CPT codes, HCPCS codes, UB92 Revenue codes, ICD-10 or ICD-9-CM procedure codes). Codes are validated for the coding scheme in effect for the dates of service for the encounter.

Providers should use only the current ICD-9-CM, ICD-10, HCPCS and CPT codes effective for the date of service. If a diagnosis, procedure or procedure modifier code does not validate against the coding scheme, the encounter record is held at Emdeon (or contracted Clearinghouse) until the error is resolved.

It is the responsibility of the physician group or facility to correct any ICD9 code errors and re-submit the corrected encounters to your contracted clearinghouse. Once the error correction passes the clearinghouse's validation checks, the encounter record will be released to Molina Healthcare, Inc.

Errors need to be corrected in a timely fashion. CMS sets deadlines based on date of service when accepting encounters. If an encounter is not corrected and re-submitted, it cannot be sent to CMS to be included in Risk Adjustment calculations. See Section F below: Risk Adjustment Submission Timetable.

E. Medicare Regulations

Molina Healthcare, Inc. requires that submissions be complete and timely in order to comply with CMS submission deadlines and current regulations. MA organizations are responsible for ensuring that data collected and submitted to CMS are acceptable for the risk adjustment process. Molina is required to verify all related entities, contractors or subcontractors to Molina’s Dual Options Plan to be accurate, complete and truthful in submission of encounter data. CMS has instituted a program of Risk Adjustment Data Validation (RADV) that includes both random and targeted medical record review of encounter data submitted to CMS.

F. Risk Adjustment Submission Timetable

Payment Year (PY)	Model Run	Date Data Due for Inclusion in Model Run	Dates of Service Included in Model Run	Payment Date Following Model Run
2012	Initial	9/2/2011	7/1/2010 - 6/30/2011	January 2012
2012	Mid-Year	3/2/2012	1/1/2011 - 12/31/2011	July 2012
2012	Final Reconciliation	1/31/2013	1/1/2011 - 12/31/2011	August 2013
2013	Initial	9/7/2012	7/1/2011 - 6/30/2012	January 2013
2013	Mid-Year	3/1/2013	1/1/2012 - 12/31/2012	July 2013
2013	Final Reconciliation	1/31/2014	1/1/2012 - 12/31/2012	August 2014
2014	Initial	9/6/2013	7/1/2012 - 6/30/2013	January 2014
2014	Mid-Year	3/7/2014	1/1/2013 - 12/31/2013	July 2014
2014	Final Reconciliation	1/31/2015	1/1/2013 - 12/31/2013	August 2015

XIX. Transition of Care

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not identified for LTC Services
Physician	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others
DME	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity
Scheduled Surgeries	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Chemotherapy/Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Dialysis Treatment	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.
Vision and Dental	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered
Medicaid Home Health and PDN	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless:	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	N/A

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not identified for LTC Services
	A significant change occurs as defined in OAC 5160-45-01; or Individuals expresses a desire to self-direct services; or after 365 days.			
Assisted Living Waiver Service			Provider maintained at current rate for the life of Demonstration.	
Medicaid Nursing Facility Services			Provider maintained at current Medicaid rate for the life of Demonstration.	
Waiver Services- Direct Care Personal Care Waiver Nursing Home Care Attendant Choice Home Care Attendant Out of Home Respite Enhanced Community Living Adult Day Health Services Social Work Counseling Independent Living Assistance	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Plan initiated changes may not occur unless: A significant change occurs as defined in OAC 5160-45-01 ; or Individuals expresses a desire to self-direct services; or after 365 days.	N/A	N/A	N/A
Waiver Services- All other	Maintain service at current level for 365 days and existing service provider at existing rate for 90 days. Plan initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider.	N/A	N/A	N/A

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not identified for LTC Services
Medicaid Community Behavioral Health Organizations (Provider types 84 & 95).	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.

XX. Glossary

Term	Definition
Appeal	A complaint lodged by a member if they disagree with certain kinds of decisions made by the health plan.
Abuse	Practices that are inconsistent with sound fiscal, business, or medical practices, that result in an unnecessary cost to the government program or in reimbursement for services that are not medically necessary, or fail to meet professionally recognized standards for healthcare.
Case Management	A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to accommodate the specific health services needed by an individual.
Claim	A request for payment for the provision of Covered Services prepared on a CMS1500 form, UB92, or successor.
CMS	Centers for Medicare and Medicaid Services
Co-insurance	The amount a member pays for medical services after the deductible is paid. Coinsurance amounts are usually percentages of approved amounts.
Co-payment or Copay	The amount a member pays for medical services such as a provider’s visit or prescription.
Deductible	The amount a member pays for healthcare or prescriptions, before the health plan begins to pay.
Disenroll	Ending healthcare coverage with a health plan.
Division of Financial Responsibility (DOFR)	A document whereby health plans assign the payment risk for any contract, dividing payment responsibilities among the plan itself, the contracted hospital, or a Medical Group/IPA.
Durable Medical Equipment (DME)	Purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically

Term	Definition
	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	Care given for a medical emergency when a member believes that his/her health is in serious danger when every second counts.
Encounter Data	Claims data for services rendered to Members who are assigned to a PCPs through a capitated Medical Group or IPA, or Staff Model Organization.
Enrollment	The process by which an eligible person becomes a member of a managed care plan.
EOB	Explanation of Benefits.
Experimental	Items and procedures determined by Medicare not to be generally accepted by the medical community.
Formulary	A list of certain prescription drugs that the health plan will cover subject to limits and conditions.
Fraud	Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. This includes any act that constitutes fraud under applicable Federal or State law.
Grievance	A complaint about the way a Medicare health plan is giving care.
Health Maintenance Organization Plan	A type of Medicare Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. HMO costs may be lower than in the Original Medicare Plan.
Home Health Agency	An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.
Hospice Services	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling.
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.
Long-Term Service and Support (LTSS)	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term service and support can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.

Term	Definition
	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	A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most healthcare costs are covered if a member qualifies for both Medicare and Medicaid.
Medically Necessary	Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the member or the doctor.
Member	A Medicare-eligible individual who is eligible and enrolled in a Molina Medicare health plan.
Network	A group of doctors, hospitals, pharmacies, and other healthcare experts hired by a health plan to take care of its Members.
Participating Provider	Participating providers agree to accept a pre-established approved amount as payment in full for service. Provider is used as a global term to include all types of providers
Primary Care Provider (PCP)	A provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse providers, nurse midwives, or physician assistants) who manages, coordinates, and monitors covered primary care (and sometimes additional services).
Quality Improvement (QI)	Program provides structure and outlines specific activities designed to improve the care, service and health of Molina Medicare Members.
Risk Adjustment	Payment methodology designed to pay appropriate premiums for each Molina Medicare Member. CMS bases its premium payment according to the health status of each Member.
Service Area	The area where a health plan accepts Members. For plans that require participating doctors and hospitals to be used, it is also the area where services are provided. The plan may disenroll Members who move out of the plans service area.
Skilled Nursing 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.

Term	Definition
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.
Waste	Healthcare spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g., coding) causes unnecessary costs to the Medicaid/Medicare programs.