PROVIDER MANUAL

Molina Healthcare of California, Inc. (Molina Healthcare or Molina)

Duals Options Medicare - Medicaid

2022

The Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated: 08/2022

Addendum to: Healthcare Services (HCS)

Medical Necessity Review

Where applicable, Molina Corporate Policies can be found on the public website at www.MolinaClinicalPolicy.com. Please note that Molina follows federal/state-specific criteria, if available, before applying Molina-specific criteria.

Addendum to: Provider Responsibilities

Provider Data Accuracy and Validation

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement.

Please visit our Provider Online Directory at: providersearch.MolinaHealthcare.com to validate your information.

For corrections and updates a convenient Provider Information Data Form can be found at: https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ca/Duals/Provider-Information-Data-Form.pdf.

Addendum to: Risk Adjustment Management Program

Interoperability

Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by Provider's Electronic Medical Records (EMR), including, but not limited to, Direct protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource). CCDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) CCDA standard.

Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If Provider does not have Direct Address, Provider, will work with its EMR vendor to set up a Direct Account, which also supports the Centers for Medicare & Medicare

Services (CMS) requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).

- If Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.

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1. DUAL OPTIONS MEDICARE-MEDICAID PRODUCTS

Dual Options Medicare-Medicaid Products Overview

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.

Molina is licensed and approved by the Centers for Medicare & Medicaid Services (CMS) to operate in California.

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

2. CONTACT INFORMATION

Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802

Provider Services Department

The Provider Services department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting and training. The department has Provider Services representatives who serve all of Molina's Provider network. Eligibility verifications can be conducted at your convenience via the Provider Portal.

Provider Portal: https://Provider.MolinaHealthcare.com

Los Angeles:
Email: MHC_LAProviderServices@MolinaHealthcare.com
Telephone: (562) 233-1753
Fax: (855) 278-0312

Sacramento:
Email: MHCSacramentoProviderServices@MolinaHealthcare.com
Telephone: (858) 974-1705 Ext. 121705
Fax: (916) 561-8559

San Bernardino:
Email: MHCIEProviderServices@MolinaHealthcare.com
Telephone: (888) 562-5442 Ext. 115937
Fax: (909) 890-4403

Riverside:
Email: MHCIEProviderServices@MolinaHealthcare.com
Telephone: (888) 562-5442 Ext. 120618
Fax: (909) 890-4403

San Diego:
Email: MHCSanDiegoProviderServices@MolinaHealthcare.com
Telephone: (858) 974-1705 Ext. 121705
Fax: (858) 503-1210

Imperial:
Email: MHCImperialProviderServices@MolinaHealthcare.com
Telephone: (619) 201-2036
Fax: (760) 679-5705

Member Services Department

The Member Services department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services representatives are available from 8:00 a.m. to 8:00 p.m., local time, Monday through Friday, excluding State holidays. Eligibility verifications can be conducted at your convenience via the Provider Portal.

Telephone: (800) 665-0898
Hearing Impaired: (TTY/TDD) 711

Claims Department

Molina strongly encourages Participating Providers to submit Claims electronically (via a clearinghouse or the Provider Portal) whenever possible.

- Access the Provider Portal at: https://provider.MolinaHealthcare.com
- EDI Payer ID 38333

To verify the status of your Claims, please use the Provider Portal. For other Claims questions contact Provider Services.

Claims Recovery Department

The Claims Recovery department manages recovery for Overpayment and incorrect payment of Claims.

Molina Dual Options Claims
P.O. Box 22702
Long Beach, CA 90801
Phone: (888) 322-4075

Compliance and Fraud AlertLine

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina AlertLine or submit an electronic complaint using the website listed below. For more information about fraud, waste, and abuse, please see the Compliance section of this Provider Manual.

Confidential Compliance Officer
Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802
Phone: (866) 606-3889
Online: https://MolinaHealthcare.alertline.com

Credentialing Department

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three years, or sooner, depending on Molina's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network.

Phone: (888) 562-5442
Fax: (888) 665-4629

Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information.

Registered nurses are available 24 hours a day, seven days a week to assess symptoms and help make good health care decisions.

Health Care Services Department

The Health Care Services (formerly Utilization Management) department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The Health Care Services (HCS) department also performs Care Management for Members who will benefit from Care Management services. Participating Providers are required to interact with Molina's HCS department electronically whenever possible. Prior Authorizations/Service Requests and status checks can be easily managed electronically.

Managing Prior Authorizations/Service Requests electronically provides many benefits to Providers, such as:

- Easy to access 24/7 online submission and status checks
- Ensures HIPAA compliance
- Ability to receive real-time authorization status
- Ability to upload medical records
- Increased efficiencies through reduced telephonic interactions
- Reduces cost associated with fax and telephonic interactions

Molina offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Molina via the Provider Portal. See the Provider Portal Quick Reference Guide or contact your Provider Services representative for registration and submission guidance.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Provider Portal: https://provider.MolinaHealthcare.com
Phone: (855) 322-4075
Prior Authorization: Option 4, Option 4, Option 2, Option 2, Option 2 24/7
Fax: (844) 251-1451

Health Management

Molina's Health Management programs will be incorporated into the Member's treatment plan to address the Member's health care needs.

Phone: (866) 891-2320
Fax: (800) 642-3691

Behavioral Health

Molina manages all components of Covered Services for behavioral health. For Member behavioral health needs, please contact us directly at (800) 665-4627 8:00am – 8:00 pm, Monday to Friday, TTY/TDD: 711. Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on the back of their Molina ID card.

Pharmacy Department

Prescription drugs are covered through Molina. A list of in-network pharmacies is available on the www.MolinaHealthcare.com website or by contacting Molina.

Phone: (855) 665-4627
Fax: (866) 290-1309

Quality

Molina maintains a Quality department to work with Members and Providers in administering the Molina Quality Program.

Phone: (800) 526-8196, ext. 126137
Fax: (562) 499-6185

3. ELIGIBILITY AND ENROLLMENT IN MOLINA DUAL OPTIONS PLAN

Enrollment Information

Members who wish to enroll in Molina Medicare Advantage plans must meet the following eligibility criteria:

Molina Healthcare of California

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

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

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

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

Furthermore, Molina does not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in Chapter 2 of the Medicare Managed Care Manual.

Members Toll-Free Telephone Numbers

Members may call our Member Contact Center toll free at: (800) 665-0898, seven days a week, from 8a.m. to 8p.m., local time, or TTY/TDD 711, for persons with hearing impairments.

Effective Date of Coverage

Molina will determine the effective date of enrollment for all enrollment requests. The effective date of coverage is determined when the complete enrollment is signed, received, following the Member's enrollment election period.

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:

- Permanently moved outside Molina's service area
- Lost Medicaid eligibility (for dual eligible enrolled in a Molina Dual Eligible Special Needs Plan)
- Lost Medicare Part A or B

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

programs. There are a number of ways that the Molina's Membership Accounting department may be informed that the Member has relocated:

- Out-of-area notification will be received from CMS on the Daily Transaction Reply Report (DTRR);
- The Member may call to advise Molina that they have permanently relocated; and/or,
- Other means of notification may be made through the Claims Department, if out-of-area claims are received with a residential address other than the one on file; (Molina does not offer a visitor/traveler program to Members)

Requested Disenrollment

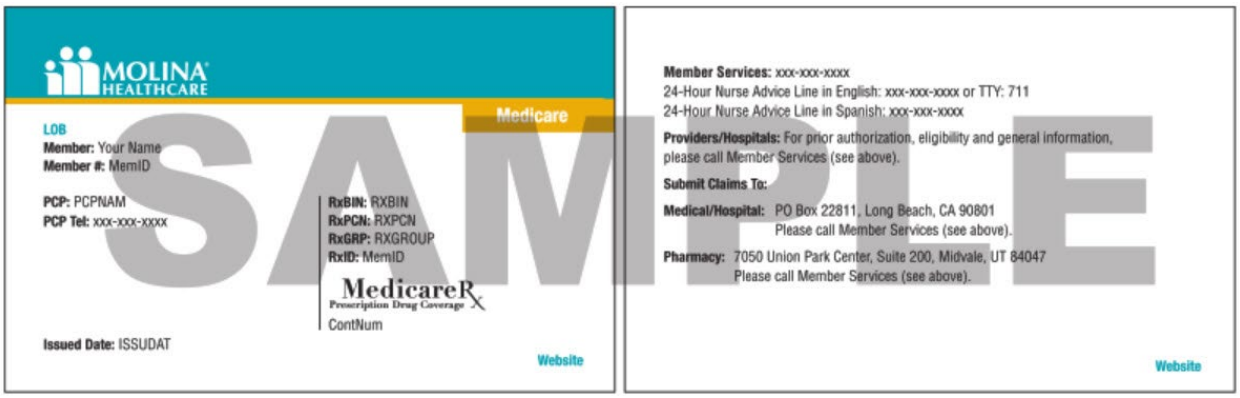
Molina will process disenrollment of Members from the health plan only as allowed by CMS regulations. Molina will request that a Member be disenrolled under the following circumstances:

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

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

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

Member Identification Card Example – Medical Services



Verifying Eligibility

To ensure payment, Molina strongly encourages Providers to verify eligibility at every visit and especially prior to providing services that require authorization. Possession of the ID card does not guarantee Member eligibility or coverage. It is the responsibility of the Provider to verify the eligibility of the cardholder.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- Provider Portal at: provider.MolinaHealthcare.com

Molina Provider Services automated IVR system at (855) 322-4075

Cost-Share

Providers can find cost-share information on an individual Molina Member through the Provider Portal at: provider.MolinaHealthcare.com or by visiting: https://www.molinahealthcare.com/members/ca/en-us/hp/duals/coverd/info/benefits.aspx.

4. BENEFIT OVERVIEW

Questions about Molina Dual Options Plan Benefits

If there are questions as to whether a service is covered or requires prior authorization, please reference the Prior Authorization tools located at on the Molina website and the Provider Portal. You may also contact Molina's Provider Contact Center c toll free at **(855) 665-4627** seven days a week, from 8 a.m. to 8 p.m., local time, or TTY/TDD 711 for persons with hearing impairments.

Links to Benefit Materials

Member benefit materials including the Summary of Benefits and the Evidence of Coverage documents can be found on Molina's website.
Link: https://www.molinahealthcare.com/members/ca/en-us/hp/duals/coverd/info/benefits.aspx

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

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

Obtaining Access to Certain Covered Services

Telehealth and Telemedicine Services

Molina Members may obtain Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services. Not all Participating Providers offer these services. The following additional provisions apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a Participating Provider
- Services are meant to be used when care is needed now for non-emergency medical issues
- Services are a method of accessing Covered Services, and not a separate benefit
- Services are not permitted when the Member and Participating Provider are in the same physical location
- Services do not include texting, facsimile or email only
- Services include preventive and/or other routine or consultative visits during a pandemic
- Member cost sharing associates to the Schedule of Benefits based upon the Participating Provider's designation for Covered Services. (i.e., Primary Care, Specialist or Other Practitioner)
- Covered Services provided through store-and-forward technology, must include

an in-person office visit to determine diagnosis or treatment.

Upon at least ten days prior notice to Provider, Molina shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of Molina. Provider shall make its personnel reasonably available to answer questions from Molina regarding telehealth operations.

For additional information on Telehealth and Telemedicine Claims and billing, please refer to the Claims and Compensation section of this Provider Manual.

Supplemental Services

A referral from the Member's PCP is not required for mandatory supplemental benefits.

Please refer to the Member Evidence of Coverage (EOC) for more information – a link is available above under "Links to Benefit Materials."

Molina partners with Providers/vendors for certain services. To find an in-network Provider/vendor, please refer to the Provider Online Directory on Molina's website at: MolinaHealthcare.com.

Provider Education on Covered Benefits and Member Access to Care

Providers are educated on the tools and information required to ensure Members understand their benefits and how to access care. This includes but is not limited to:

- How to identify Medicare and Medicaid covered benefits by accessing the appropriate plan or state agency materials (see hyperlinks below)
- How to access Medicaid covered services including waiver services such as LTSS, IHSS, or Behavioral Services

Medicaid-Covered Benefits

Medicaid-Covered Benefits can be found in the State's Medicaid website at: https://www.molinahealthcare.com/members/ca/en-us/-/media/Molina/PublicWebsite/PDF/members/ca/en-us/Medi-Cal/2022-Medi-Cal-EOC.pdf/.

Service Type	Vendor Details	
Vision	Benefits include services such as routine vision services, frames, and lenses.	
	March Vision Attention: Claims Services 6701 Center Drive West, Suite 790 Los Angeles, CA 90045 Tel: (844) 336-2724	CA: HMO SNP only
	VSP – Vision Service Plan Insurance Company	Phone: (800) 877-7195

Medical and Non-Medical Transportation

Member transportation is covered by Molina in accordance with Dual Plan Letter 18-001 and coordinated through Secure Transportation for all Molina Dual Options (MMP) Plan Members. Detailed information about benefits can be found in the **Evidence of Coverage booklets** sent to each Molina Member.

Emergency Medical Transportation

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

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

Non-Emergency Medical Transportation (NEMT)

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

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

maximum of twelve (12) months
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport)
- Certification Statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested

NEMT Modes of Transport and Criteria

Mode of Transport	Criteria
Ambulance	• Transfers between facilities for Members who require continuous intravenous medication, medical monitoring, or observation • Transfers from an acute care facility to another acute care facility • Transport for Members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use) • Transport for Members with chronic conditions who require oxygen if monitoring is required
Litter Van: When the Member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following	• Requires that the Member be transported in a prone or supine position, because the Member is incapable of sitting for the period of time needed to transport • Requires specialized safety equipment over and above that normally available in passenger • cars, taxicabs or other forms of public conveyance

Wheelchair Van: When the Member's medical and physical condition does not meet the need for litter van services, but meets any of the following	• Renders the Member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport • Requires that the Member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation. • Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance. • Members with the following conditions qualify for wheelchair van transport: Members who suffer from severe mental confusion; Members with paraplegia; Dialysis recipients; • Members with chronic conditions who require oxygen but do not require monitoring

Mode of Transport	Criteria
Air transport: Only provided under the following conditions	When transportation by air is necessarybecause of the Member's medical condition or because practical considerations render ground transportation not feasible

Non-Emergency Non-Medical Transportation (NMT)

Non-Emergency non-medical transportation (NMT) is available to Member when used to obtain medically necessary services. They must have no other form of transportation available. NMT does not include transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with State and local statutes, ordinances, or regulations.

Molina provides the following NMT services:

- Round-trip transportation for a member by passenger car, taxicab, bus, train, or

any other form of public or private conveyance (including a private vehicle). NMT also includes mileage reimbursement for medical purposes when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

Round-trip NMT is available for the following:

- Members picking up drug prescriptions that cannot be mailed directly to the member
- Members picking up medical supplies including prosthetics, orthotics, or other equipment
- Other medically necessary services

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

Additional information regarding the Transportation benefit is available by contacting Provider Services at (888) 562-5442.

5. QUALITY

Maintaining Quality Improvement Processes and Programs

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

The address for mail request is:
Molina Dual Options Plan – (CA Health Plan)
Quality Department
200 Oceangate, Suite 100
Long beach, CA 90802

This Provider Manual contains excerpts from the Molina Quality Improvement Program. For a complete copy of Molina's Quality Improvement Program, you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

Molina has established a Quality Improvement Program that complies with regulatory requirements and accreditation standards. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service, and health of our Members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure, and responsibilities.

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

- Have a Quality Improvement Plan in place
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential Quality of Care and/or Critical Incident investigations
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services and Member experience
- Allow Molina to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability
- Allow access to Molina Quality personnel for site and medical record review processes

Patient Safety Program

Molina Dual Options Plan's Patient Safety Program identifies appropriate safety projects

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

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

Quality of Care

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

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgery on a patient

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

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. PCPs should maintain the following medical record components, that include but are not limited to:

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

Medical Record Keeping Practices

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

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

Content

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

- Each page in the record contains the patient's name or ID number
- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact
- Legible signatures and credentials of Provider and other staff members within a paper chart
- All Providers who participate in the Member's care
- Information about services delivered by these Providers
- A problem list that describes the Member's medical and behavioral health conditions
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known)
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place
- Past medical and surgical history, including physical examinations, treatments, preventive services, and risk factors
- Treatment plans that are consistent with diagnosis

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

Organization

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

Retrieval

- The medical record is available to Provider at each Encounter
- The medical record is available to Molina for purposes of Quality Improvement
- The medical record is available to the applicable State agency and/or Federal agency and the External Quality Review Organization upon request
- The medical record is available to the Member upon their request
- A storage system for inactive member medical records which allows retrieval within 24 hours, is consistent with State and Federal requirements, and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one year past their 20th birthday but, never less than 10 years

- An established and functional data recovery procedure in the event of data loss

Confidentiality

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

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

Additional information on medical records is available from your local Molina Quality department. For additional information regarding HIPAA, please see the Compliance section of this Provider Manual.

Access to Care Access to Care

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

Appointment Access

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

Medical Appointment

Appointment Type	Standard
Emergency Care	Immediately
PCP Urgent Care without prior authorization	Within ≤ 48 hours of the request.
PCP Urgent Care with prior authorization	Within ≤ 96 hours of the request.

Appointment Type	Standard
PCP Routine or Non-Urgent Care Appointments	Within ≤ 10 business days of the request.
PCP Adult Preventive Care	Within ≤ 20 business days of the request.
Specialist Urgent Care without prior authorization	Within ≤ 48 hours of the request.
Specialist Urgent Care with prior authorization	Within ≤ 96 hours of the request.
Specialist Routine or Non-Urgent Care	Within ≤ 15 business days of the request.
Routine or Non-Urgent Care Appointment for Ancillary Services	Within ≤ 15 working days of the request.
Children's Preventive Period Health Assessments (Well-Child Preventive Care) Appointments	Within ≤ 7 working days of the request.
After Hours Care	24 hours/day; 7 day/week availability
Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA) for a New Member (under eighteen (18) months of age)	Within 120 days of the enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages 2 and younger, whichever is less.
Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA) for a New Member (over eighteen (18) months of age through 20 years of age)	Within 120 days of the enrollment. The IHA and SHA must follow most recent AAP periodicity schedule appropriate for the child's age, and the scheduled assessments and services must include all content required by the Child Health and Disability Prevention program (CHDP) for the lower age nearest to the current age of the child.
Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA) for a New Member (age 21 years and older)	Within 120 days of the enrollment.
Maternity Care Appointments for First Prenatal Care	Within ≤ 2 weeks of the request.
Office Telephone Answer Time (during office hours)	Within ≤ 30 seconds of call.

Office Response Time for Returning Member Calls (during office hours)	Within same working day of call.
Office Wait Time to be Seen by Physician (for a scheduled appointment)	Should not exceed 30 minutes from the appointment time.
After-Hour Instruction for Life-Threatening Emergency (when office is closed)	Life-threatening emergency instruction should state: “If this is a life-threatening emergency, hang up and dial 911.”
Physician Response Time to After-Hour Phone Message, Calls and/or Pages	Within 30 minutes of call, message and/or page. A clear instruction on how to contact the physician or the designee (on-call physician) must be provided for Members.

Behavioral Health Appointment

Appointment Type	Standard
Urgent Care with a Behavioral Health Provider without prior authorization	Within ≤ 48 hours of the request.
Urgent Care requiring prior authorization with a Behavioral Health Provider	Within ≤ 96 hours of the request.
Routine or Non-Urgent Care Appointments with a Behavioral Health Provider	Within ≤ 10 working days of the request.
Behavioral Health Non-life-threatening emergency	Within ≤ 6 hours of the request.
BH – Routine Follow Up with Prescribers (i.e. Psychiatrist)	Within ≤ 30 business days from the initial appointment for a specific condition
BH – Routine Follow Up with Non-Prescribers (i.e. Psychologist)	Within ≤ 20 business days from the initial appointment for a specific condition
Routine or Non-Urgent Care Appointment with a Non- Physician Mental Health Provider	Within ≤ 10 working days of the request.

Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-Life-Threatening Emergency	Within ≤ 6 hours
Urgent Care	Within ≤ 48 hours
Initial Routine Care Visit	Within ≤ 10 business days

Additional information on appointment access standards is available from your local Molina Quality department.

Office Wait Time

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

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, seven 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. Voicemail alone after-hours is not acceptable.

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments.
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the Molina Provider Services department toll free at: (888) 562-5442 or TTY/TDD 711.
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time.
4. Special needs of Members must be accommodated when scheduling appointments. This includes but is not limited to wheelchair-using Members and Members requiring language interpretation.
5. A process for Member notification of preventive care appointments must be established. This includes but is not limited to immunizations and mammograms.
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test

results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit their 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 their panel to new Members, Molina must receive 30 calendar day advance written notice from the Provider.

Women's Health Access

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

Additional information on access to care is available from your local Molina Quality department.

Monitoring Access for Compliance with Standards

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

Provider Network adherence to access standards is monitored via one or more of the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

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

trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Quality of Provider Office Sites

Quality of Provider Office Sites

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

- Physical Accessibility
- Physical Appearance
- Adequacy of Waiting and Examining Room Space

Physical Accessibility

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

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

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

Administration & Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom

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

Advance Directives (Patient Self-Determination Act)

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

Advance Directives are a written choice for health care. There are two types of Advance Directives:

- **Durable Power of Attorney for Health Care:** Allows an agent to be appointed to carry out health care decisions.
- **Living Will:** Allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.

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

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

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

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

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

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

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

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

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

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

Well Child/Adolescent Visits

Visits consist of age-appropriate components, that include but are not limited to:

- Comprehensive health and developmental history
- Nutritional assessment
- Height and weight and growth charting
- Comprehensive unclothed physical examination
- Appropriate immunizations according to the Advisory Committee on Immunization Practices
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool
- Vision and hearing tests
- Dental assessment and services
- Health education, including anticipatory guidance such as child development, healthy lifestyles. accident and disease prevention
- Periodic objective screening for social emotional development using a recognized, standardized tool
- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit

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

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

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually.

Performance below Molina's standards may result in a Corrective Action Plan (CAP) with a request the Provider submit a written corrective action plan to Molina within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

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

Sensitive Services means those services related to:

- Sexual Assault
- Drug or alcohol abuse for children 12 years of age or older
- Pregnancy
- Family Planning
- Sexually transmitted diseases for children 12 years of age or older
- Abortion services
- HIV testing/counseling
- Mental Health Services
- Health Education Services

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

Timely Access to Services and Treatment Consent

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

Family Planning Services

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

Privacy and Security of Protected Health Information

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

laws and regulations pertaining to privacy of health information:

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

Quality Improvement Activities and Programs

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

Health Management and Care Management

The Molina Health Management and Care Management programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases.

For additional information please see the Health Management and Care Management headings in the Health Care Services section of this Provider Manual.

Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriate established authority. Clinical Practice Guidelines are reviewed at least annually and more frequently as needed when clinical evidence changes and approved by the Quality Improvement Committee.

Molina Clinical Practice Guidelines include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults

- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services departments. The guidelines are disseminated through Provider newsletters, electronic Provider Bulletins and other media and are available on the Molina Website. Individual Providers or Members may request copies from your local Molina Quality department.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Recommendations for Preventive Pediatric Health Care
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States, 2021
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

All guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to Providers at: www.MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

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

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Behavioral Health Satisfaction Assessment
- Health Outcomes Survey (HOS)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

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

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

Molina's most recent results can be obtained from your local Molina Quality departmentor by visiting our website at: www.MolinaHealthcare.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)

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

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is the tool used by Molina to summarize Member satisfaction with the Providers, health care and services they receive. CAHPS® examines specific

measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care, and Getting Needed Prescription Drugs. The CAHPS® survey is administered annually in the spring to randomly selected Members by an approved NCQA- certified vendor.

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

Behavioral Health Satisfaction Assessment

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

Medicare Health Outcomes Survey (HOS)

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

Provider Satisfaction Survey

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

Effectiveness of Quality Improvement Initiatives

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

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

What Can Providers Do?

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

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Provider Portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Molina Quality department.

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

Merit-Based Incentive Payment System (MIPS)

Under the Medicare Access and CHIP Reauthorization Act (MACRA), CMS implemented the Quality Payment Program Merit-based Incentive Payment System (MIPS). This is a quality payment program that eligible Providers under original Medicare will participate in and does not impact how Medicare Advantage and MMP plans are required to pay. Due to this being a quality program, Providers will not receive a bonus or a withhold for the Quality Payment Program Merit-based Incentive Payment System (MIPS), unless it is specifically in the agreement you have with Molina. Please contact your Provider Services Representatives for other quality programs Molina offers.

Provider/Practitioner Review Process

Provider/Practitioner Facility Site Review (FSR)

Effective July 1, 2002, the State of California's Health and Human Services Agency mandated that all County Organized Health Systems (COHS), Geographic Managed Care (GMC) Plans, Primary Care Case Management (PCCM) Plans, and Two-Plan Model Plans use the Full Scope Site Review and Medical Record Review Evaluation Tool. For more details on FSR, please reference: Facility Site Review.

All primary care sites serving Medi-Cal managed care Members must undergo an initial site review and subsequent periodic site review every three (3) years using the current DHCS approved facility site review survey tool. Managed care health plans may review sites more frequently per local collaborative decision or when determined necessary, based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues. For more details on FSR, please reference: Facility Site Review.

The Medi-Cal managed care health plans within the county have established systems and procedures for the coordination and consolidation of site audits for mutually shared PCP sites and facilities to avoid duplication and overlapping of FSR reviews. For more details on FSR, please reference: Facility Site Review.

All Primary Care Physicians must maintain an Exempted or Conditional pass on site review to participate in MHC Provider Network. The evaluation scores are based on standardized scoring mechanism established by DHCS. Please refer to the Credentialing section of the Provider Manual for expanded information about FSR requirements. For more details on FSR, please reference: Facility Site Review.

Medical Record Review (MRR)

The on-site Practitioner/Provider medical record review is a comprehensive evaluation of the medical records. MHC will provide information, suggestions, and recommendations to assist Practitioners/Providers in achieving the standards. For more details on MRR, please reference: Facility Site Review.

All PCPs must complete and pass the medical record review at each practice location. Medical Record Reviews are conducted in conjunction with the Facility Site Review, prior to participating in MHC Provider Network and at least every three (3) years thereafter. For more details on MRR, please reference: Facility Site Review.

All Primary Care Physicians must maintain an Exempted or Conditional pass on medical record review to participate in MHC Provider Network. The evaluation scores are based on standardized scoring mechanism established by DHCS. Please refer to the Credentialing section of the Provider Manual for expanded information about MRR requirements. For more details on MRR, please reference: Facility Site Review.

Physical Accessibility Review Survey (PARS)

In accordance with the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) policy letter 11-013, managed care health plans are required to assess the level of physical accessibility of Provider sites, including all Primary Care Physicians, specialists and ancillary Providers that serve a high volume of Seniors and Persons with Disabilities (SPD). The Physical Accessibility Review Survey (PARS) tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA). For more details on PARS, please reference: Facility Site Review.

Unlike the Facility Site Review and Medical Records Review, PARS is a survey and no corrective action is required. Please refer to the Credentialing section of the Provider Manual for expanded information about PARS requirements. For more details on PARS, please reference: Facility Site Review.

Child Health and Disability Prevention (CHDP) Reviews

CHDP is a State preventive service program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

MHC provides health assessment, preventive health care and coordination of care to eligible Members through the CHDP program.

CHDP specific questions are incorporated into the Medical Record Review Tool. The CHDP review may be done concurrently with the medical record review.

CHDP requirements are detailed in the Medical Record Pediatric Review Guidelines.

Comprehensive Perinatal Services Program (CPSP) Review

The CPSP is designed to increase access to prenatal care and to improve pregnancy outcomes. The services of this program include health and nutrition education, psychosocial assessment, treatment planning, and periodic reassessment. CPSP must be offered to all MHC Medi-Cal Members, but participation is voluntary. Refusal of CPSP must be documented in the patient's obstetrical record.

6. HEALTHCARE SERVICES (HCS)

Healthcare Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated approach to coordinating care. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services.

Utilization Management (UM)

The Molina Utilization Management program provides pre-service authorization, inpatient authorization management, and concurrent review of inpatient and continuing services. Molina aims to ensure that services are medically necessary and an appropriate use of resources for the Member. Some of the elements of the UM program are:

- Evaluating the medical necessity and efficiency of health care services across the continuum of care
- Applying appropriate criteria based on CMS guidelines and, when applicable, State requirements
- Providing pre-admission, admission, and inpatient hospital and skilled nursing facility review
- Ensuring that services are available in a timely manner, in appropriate settings
- Ensuring that qualified health care professionals are engaged in the UM decision making process when appropriate
- Ensuring the appropriate application of Member benefit coverage and coverage criteria. For dual eligible Members:
    - If Prior Authorization (PA) is submitted to Molina for any non-covered benefits, Molina will inform the Provider on who, including their contact information, the PA should be submitted to via denial notification.

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

Medical Necessity Review

Molina only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. Medical necessity decisions are made by a physician or other appropriate licensed health care personnel with sufficient medical expertise and knowledge of the appropriate coverage criteria. These medical professionals conduct medical necessity reviews in accordance with CMS guidelines (such as national and local coverage determinations) and use nationally recognized

evidence-based guidelines, third party guidelines, guidelines from recognized professional societies, and peer reviewed medical literature, when appropriate. Providers may request to review the criteria used to make the final decision.

Where applicable, Molina Corporate Policies can be found on the public website at: www.MolinaClinicalPolicy.com. Please note that Molina follows federal/state-specific criteria, if available, before applying Molina-specific criteria.

Requesting Prior Authorization

Contracted Providers are responsible for requesting prior authorization of services when required by Molina policy, which may change from time to time. Failure to obtain prior authorization before rendering a service may result in a pre-service denial with Provider liability and/or denial of the Claim. The Member cannot be billed when a contracted Provider fails to follow the Utilization Management requirements for the Plan, including failure to obtain prior authorization before the Member receives the item or service. Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

Molina requires prior authorization for specified services. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS code. The prior authorization list is customarily updated quarterly, but may be updated more frequently, and is posted on the Molina website at: MolinaHealthcare.com. The Prior Auth Lookup Tool is also available in the Molina Healthcare Provider Portal.

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

- Member demographic information (name, date of birth, Molina ID number, health plan)
- Provider demographic information (ordering provider, servicing Provider, and referring Provider (when appropriate)
- Relevant Member diagnoses and ICD-10 codes
- Requested items and/or services, including all appropriate CPT and HCPCS codes
- Location where services will be performed (when relevant)
- Supporting clinical information demonstrating medical necessity under Medicare guidelines (and/or State guidelines when applicable)

Members and their authorized representatives may also request prior authorization of any item or service they want to receive. In this case, the physician or other appropriate Provider will be contacted to confirm the need for and specific details of the request.

Contracted Providers are expected to cooperate with Molina UM processes and guidelines, including submission of sufficient clinical information to support the medical necessity, level of care, and/or site of service of the items and/or services requested. Contracted Providers must also respond timely and completely to requests for additional information. If Molina determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Contract or the Provider Manual, a denial may be issued with Provider liability. Members cannot be held responsible when the Provider fails to follow the terms and conditions of the relevant Provider Agreement or this Provider Manual. For information on the contracted Provider Claims appeals process see the Claim Reconsideration subsection located in the Claims and Compensation section of this Provider Manual.

Requests for prior authorization may be sent by telephone, fax, mail, or via the Provider Portal.

Provider Portal: Contracted Providers are encouraged to use the Provider Portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Provider Portal. The benefits of submitting your prior authorization request through the Provider Portal are:

- Create and submit prior authorization requests
- Check status of prior authorization requests
- Receive notification of change in status of prior authorization requests
- Attach all supporting medical documentation

Phone: Prior authorizations can be initiated by contacting the appropriate Utilization Management department at the number provided below. Supporting clinical information should be submitted by fax or via the Provider Portal for timely case processing.

For Advanced Imaging – California	(855) 714-2415
For Pharmacy (Part D and Part B drugs and for Medicaid-covered drugs when the Member is in an integrated plan providing Medicaid wrap benefits, such as a FIDE SNP or MMP)	(800) 665-3086
For all other Medicare MMP prior authorization requests (physical health and behavioral health)	Central Medicare: Prior Auth (844) 251-1450 Central MMP: Prior Auth (844) 251-1451

Fax: The Prior Authorization Request Form can be faxed to the appropriate Utilization Management department at the number provided below:

For Advanced Imaging – California	(877) 731-7218
For Pharmacy (Part D and Part B drugs and for Medicaid-covered drugs when the member is in an integrated plan providing Medicaid wrap benefits, such as a FIDE SNP or MMP)	Part D: (866) 290-1309 Part B (J-Codes): (800) 391-6437
For Medicare Hospital Inpatient Admission and Concurrent Review (physical health)	Fax: (844) 834-2152
For Medicare prior authorization (physical health and behavioral health)	Fax: (844) 251-1450

Mail: Prior authorization requests and supporting documentation can be submitted via U.S. Mail to the appropriate Utilization Management department at the address provided below:

For Advanced Imaging – California	Molina Healthcare ATTN: Advanced Imaging 200 Oceangate, Suite 100 Long Beach, CA 90802
For Pharmacy (Part D and Part B drugs and for Medicaid-covered drugs when the Member is in an integrated plan providing Medicaid wrap benefits, such as a FIDE SNP or MMP)	Molina Healthcare ATTN: Medicare Pharmacy Dept. 7050 Union Park Avenue, STE 200 Midvale, UT 84047
For all other Medicare & MMP prior authorization requests (physical health and behavioral health)	Molina Healthcare ATTN: Medicare Utilization Management 200 Oceangate, Suite 100 Long Beach, CA 90802

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

Notwithstanding any provision in the Provider Agreement that requires Provider to obtain a prior authorization directly from Molina, Molina may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the MolinaHealthcare.com website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix

Affirmative Statement about Incentives

Health care professionals involved in the UM decision-making process base their decisions on the appropriateness of care and services and the existence of coverage. Molina does not specifically reward practitioners or other individuals for issuing denials of coverage or care and does not provide financial incentives or other types of compensation to encourage decisions that result in under-utilization or barriers to care.

Timeframes

Prior authorization decisions are made as expeditiously as the Member's health condition requires and within regulatory timeframes.

Medicare organization and coverage determination timeframes for pre-service requests are:

Expedited (Non-Part B, Non-Part D drug)	**72 hours – Medicare guidance allows written notice to follow within 3 calendar days after verbal notice to the member
Expedited Part B drug	24 hours
Expedited Part D drug	24 hours
Standard (Non-Part B, Non-Part D drug)	**14 calendar days
Standard Part B drug	72 hours
Standard Part D drug	72 hours

***Timeframes for fully integrated plans such as a FIDE SNP or MMP may vary with regulatory and contractual requirements.*

****Extensions may be allowed under specific conditions (with the exception of requests involving a Part B or Part D drug).*

A Provider may request that a UM decision be expedited if following the standard timeframe could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. Providers must ask that a request be expedited only when this standard is supported by the Member's condition.

Communication of Pre-service Determinations

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax.

When a pre-authorization request is denied with Member liability, the Member is issued a denial notice informing them of the decision and their appeal rights with a copy to the Provider. The Member's appeal rights are discussed further in the Medicare Member Grievances and Appeals section of this Provider Manual.

When a pre-authorization request is denied with Provider liability, the Provider is issued a denial notice by fax informing them of the decision. Additional information on the contracted Provider Claims appeal process can be found in the Claim Reconsideration subsection found in the Claims and Compensation section of this Provider Manual.

Peer-to-Peer Discussions and Re-openings

Contracted Providers may request a peer-to-peer conversation with a Molina Medical Director. Once a final adverse decision is made, however, the decision may not be reversed if Member liability is assigned (i.e., the Member is issued a denial notice with Medicare appeal rights) unless the CMS requirements for a reopening are met. CMS allows Medicare Advantage plans to use the reopening process only sparingly. Requirements for a reopening include clear clerical error, the procurement of new and material evidence that was not available or known at the time of the decision that may result in a different conclusion, or evidence that was considered in making the decision clearly shows on its face that an obvious error was made at the time of the decision (i.e., the decision was clearly incorrect based on all the evidence presented). Providers may not use the reopening process for the routine submission of additional information. Re-openings are not allowed once an appeal is filed by the Provider or the Member (or their authorized representative). Molina Medical Directors are available prior to the time of the decision to discuss any unique circumstances to be considered in the case.

Adverse decisions for which only provider liability is assigned and that do not involve an adverse determination or liability for the member may be subject to a peer-to-peer conversation. A peer-to-peer conversation is an opportunity to clarify the clinical information or to provide newly discovered clinical information. Molina will not allow contracted Providers to use the peer-to-peer process as a vehicle for routine failure to provide sufficient information in the Utilization Management process or to avoid the contracted Provider Claims appeals process. Contracted Providers are responsible for providing all information to support the request within the required timeframes. Additional information on the contracted Provider Claims appeals process can be found in the Claim Reconsideration subsection found in the Claims and Compensation section of this Provider Manual.

Open Communication About Treatment

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

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

Utilization Management Functions Performed Exclusively by Molina

The following UM functions are conducted by Molina and are **never delegated**:

1. **Transplant -** Molina does not delegate management of transplant cases to the medical group. Providers are required to notify Molina's UM Department (Transplant Unit) when the need for a transplant evaluation is identified. Contracted Providers must obtain prior authorization from Molina Medicare for transplant evaluations and surgery. Upon notification, Molina conducts medical necessity review. Molina selects the facility to be accessed for the evaluation and possible transplant.
2. **Clinical Trials -** Molina does not delegate to Providers the authority to authorize payment for services associated with clinical trials. See Clinical Trials below for additional information.
3. **Experimental and Investigational Reviews -** Molina does not delegate to Providers the authority to determine and authorize experimental and investigational (E & I) reviews.

Clinical Trials

National Coverage Determination (NCD) 310.1 provides that Medicare covers the routine costs of qualifying clinical trials (as defined in the NCD) as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials. All other Medicare rules apply. Routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries that are provided in either the experimental or control arm of a clinical trial except:

- The investigational item or service itself unless otherwise covered outside of the clinical trial;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct management of the patient; and

- Items and services customarily provided by the research sponsors free of charge for any enrollee in the clinical trial.

Routine costs in clinical trials include:

- Items or services that are typically provided absent a clinical trial;
- Items or services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service and in particular, for the diagnosis or treatment of complications.

For non-covered items and services, including items and services for which Medicare payment is statutorily prohibited, Medicare only covers the treatment of complications arising from the delivery of the non-covered item or service and unrelated to reasonable and necessary care. However, if the item or service is not covered by virtue of a national non-coverage policy (i.e., an NCD) and is the focus of a qualifying clinical trial, the routine costs of the clinical trial will be covered by Medicare but the noncovered item or service itself will not.
Clinical trials must meet qualifying requirements. Additional information on these requirements and the qualifying process can be found in NCD 310.1.

If the member participates in an unapproved study, the member will be liable for all costs associated with participation in that study. Members can obtain additional information about coverage for the costs associated with clinical trials and member liability for Medicare cost-sharing amounts in their Evidence of Coverage (EOC) or Member Handbook.

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. These entities are required to perform these functions in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Emergency Services, Urgent Care, and Post-Stabilization Services

Molina covers Emergency Services as well as Urgently Needed Services and Post-Stabilization Care for members in accordance with applicable federal and state law. Medicare defines Emergency Services are covered services provided to evaluate or treat an Emergency Medical Condition. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant

woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Urgently Needed Services are covered services that:

1. Are not Emergency Services, but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;
2. Are provided when (a) the member is temporarily absent from the Plan's service area and therefore, the member cannot obtain the needed service from a network provider; or (b) when the member is in the Plan's service area but the network is temporarily unavailable or inaccessible; and
3. Given the circumstances, it was not reasonable for the member to wait to obtain the needed services from their regular Plan provider after returning to the service area or the network becomes available.

Post-Stabilization Care Services are covered services that are:

1. Related to an Emergency Medical Condition;
2. Provided after the member is stabilized; and
3. Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition.

Emergency Services and Urgently Needed Services do not require pre-authorization, although contracted provider notification requirements may apply. See Emergency Inpatient Admissions below.

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

Inpatient Admission Notification and Management

Elective Inpatient Admissions

Molina requires prior authorization for all elective/scheduled inpatient admissions and procedures to any inpatient facility. (i.e., including hospitals, SNFs, and other inpatient settings). Contracted SNFs, long-term acute care hospitals (LTACHs), and acute inpatient rehabilitation (AIR) facilities/units must obtain prior authorization before admitting the member.

Inpatient facilities are also required to notify Molina of the admission within 24 hours or by the following business day or as otherwise specified in the relevant Provider Agreement. Inpatient notifications may be submitted by fax. Contact telephone numbers and fax numbers are provided in the Requesting Prior Authorization section of this Provider Manual.

Continued stay must be supported by clinical documentation supporting the level of care. Failure to obtain prior authorization, to provide timely notice of admission, or to support the level of care may result in denial with provider liability. Members cannot be held liable for failure of a contracted provider to follow the terms of the relevant Provider Agreement and this Provider Manual. Additional information on the contracted Provider claims appeal process can be found in the Claim Reconsideration subsection found in the Claims and Compensation section of this Provider Manual.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day or as otherwise specified in the relevant Provider Agreement. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Notification must include member demographic information, facility information, date of admission and clinical information supporting the level of care. Notifications may be submitted by fax. Contact telephone numbers and fax numbers are noted in the Requesting Prior Authorization section of this Provider Manual.

Prior authorization is not required for an observation level of care. Once the member is stabilized and a request for inpatient admission is made or the observation period expires, contracted providers are responsible for supporting an admission level of care. Failure to provide timely notice of admission or to support an admission level of care may result in a clinical level of care denial with provider liability. Members cannot be held liable for a contracted provider's failure to follow the terms of the relevant Provider Agreement and this Provider Manual. Additional information on the contracted provider claims appeal process can be found in the Claim Reconsideration subsection found in the Claims and Compensation section of this Provider Manual.

Emergency Department Support Unit

Molina highly encourages that requests for authorization of post-stabilization services be communicated telephonically via the EDSU. While the Member is in the Emergency Room, call (844) 9-Molina or (844) 966-5462. Additionally, clinical records for authorization of post-stabilization care can be faxed to the dedicated EDSU fax number: (877) Molina 5 or (877) 665-4625. This fax number is used exclusively for Members currently in the ER, to help expedite requests and assist with discharge planning.

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

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

- Assisting in determining appropriate level of placement using established clinical guidelines
- Issuing authorizations necessary, for admission, transportation, or home health

- Involving a Hospitalist or On-Call Medical Director for any Peer-to-Peer reviews needed
- Working with pharmacy to coordinate medications or infusions as needed
- Obtaining SNF placement if clinically indicated
- Coordinating placement into Case Management with Molina when appropriate
- Beginning the process of discharge planning and next day follow-up with a Primary Care Provider if indicated

Notification Requirements

When a member receives stabilization services in the hospital Emergency Room, Molina requires timely notification to the EDSU for any post stabilization services, i.e. inpatient admission.

Molina strongly recommends that requests for authorization of post-stabilization services be communicated telephonically via the EDSU. Contact with the EDSU will be considered a formal request that requires a determination for post stabilization services and will be responded to within 30 minutes.

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

Fax clinical documentation to: (877) Molina 5 or (877) 665-4625
If there is insufficient clinical information to render an approval during the post stabilization timeframe, the EDSU nurse will contact the Molina physician on call for consultation. If the physician determines that clinical information does not support medical necessity, a denial will be issued. Denials may be overturned if additional clinical information is provided to support medical necessity for the admission.

If the request for post stabilization services at a non-par hospital is denied, the EDSU staff will work with the hospital to arrange transfer of the member to a Molina contracted facility. In addition, if the request for post stabilization services is for a higher level of care, the hospital will initiate transfer with the EDSU. The EDSU staff will work with the hospital to facilitate transfer of the member to a facility that is able to provide the level of care needed by the member.

For post stabilization services that are denied, the hospital may submit claims for observation level of care for payment consideration.

Notifications received from hospitals, where a post-stabilization admission determination is **NOT** expected by the hospital within 30 minutes, will follow the standard Molina UM process.

After hours, weekends and holidays, please call: (844) 9-Molina or (844) 966-5462.

Inpatient at Time of Termination of Coverage

Members hospitalized on the day that Member in the Plan terminates are usually covered through discharge. Specific Plan rules and Provider Agreement provisions may apply.

NOTICE Act

Under the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), hospitals (including critical access hospitals) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including a Medicare Advantage enrollee) who receives observation services as an outpatient for more than 24 hours. The MOON is issued to inform the beneficiary that they are an outpatient receiving observation services and not a hospital inpatient. The beneficiary is informed that their services are covered under Part B and that Part B cost-sharing amounts apply. Additional information is provided to the beneficiary with regard to how an observation stay may affect their eligibility for a SNF level of care and that Part B does not cover self-administered drugs.

Inpatient/Concurrent Review

Molina performs concurrent inpatient review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment, and development of appropriate discharge plans. Concurrent review is performed for inpatient stays regardless of setting (i.e., including hospital, SNF, and other inpatient setting), although the cadence and extent of concurrent review may vary depending on the setting and the member's circumstances. Performing these functions requires timely clinical. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Requested clinical updates must be received from the inpatient facility within 24 hours of the request or such other time as may be indicated in the request.

Failure to provide timely clinical updates may result in denial of authorization for the remainder of the inpatient admission with provider liability dependent on the circumstances and the terms of the relevant Provider Agreement. Members cannot be held liable for a contracted provider's failure to follow the terms of the relevant Provider Agreement or this Provider Manual.

Molina will authorize hospital care as an inpatient when the clinical record supports the medical necessity of continued hospital stay. An observation level of care should be provided first when appropriate. Upon discharge, the Provider must provide Molina with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. UM staff work communicate with hospital discharge planners to determine the most appropriate discharge setting for our members. The clinical staff review medical necessity and

appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is important to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

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

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the readmission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

Out of Network Providers and Services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process Molina requires Members to receive non-emergency medical care within the participating, contracted network of Providers services provided by non-contracted, Providers must be prior authorized. Exceptions include Emergency Services and medically necessary dialysis services obtained by the member when they are outside the service area. See the section on Emergency Services, Urgent Care, and Post-Stabilization Services above. When no exception applies, Molina will determine whether there are contracted providers within the service area willing and able to provide the items or services requested for the Member.

Avoiding Conflict of Interest

Termination of Ongoing Services

Termination of Inpatient Hospital Services

Hospitals are required by CMS regulations to deliver the Important Message from Medicare (IM, Form CMS-10065), to all Medicare beneficiaries (including Medicare Advantage enrollees) who are hospital inpatients within 2 calendar days of admission. This requirement is applicable to all hospitals regardless of payment type or specialty. Delivery must be made to the member or the member's authorized representative in accordance with CMS guidelines. A follow-up copy of the IM is delivered no more than 2 calendar days before the planned discharge date.

The IM informs beneficiaries of their rights as a hospital inpatient, including their right to appeal the decision to discharge. Hospitals must deliver the IM in accordance with CMS guidelines and must obtain the signature of the beneficiary or his or her representative and provide a copy at that time. When the member is no longer meeting criteria for

continued inpatient stay and the hospital has not initiated discharge planning, Molina may require that the hospital issue a follow-up copy of the IM and notify the member of their discharge date or provide additional clinical information supporting an inpatient level of care. Failure to do so may result in the denial of continued hospital services with provider liability. The member cannot be held liable for any continued care (aside from any applicable deductibles or copayments) without proper notification that includes their appeal rights located within the IM and if the member exercises their appeal rights, not until noon of the day after the QIO notifies the member of a determination adverse to the member.

When the member exercises their appeal rights with the Quality Improvement Organization (QIO), the hospital is required to properly complete and deliver the Detailed Notice of Discharge (DND, Form CMS-10066) to the QIO and the member as soon as possible and no later than noon follow the day of the QIO's notification to the hospital of the appeal. The hospital is also required to provide all information that the QIO requires to makes its determination. At the member's request, the hospital must provide to the member a copy of all information provided to the QIO, including written records of any information provided by telephone. This documentation must be provided to the member no later than close of business of the first day that the member makes the request.

The exhaustion of a member's covered Part A hospital days is not considered to be a discharge for purposes of issuing the IM.

Termination of SNF, CORF, and HHA Services

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice issued to Medicare beneficiaries to inform them of the termination of ongoing services (discharge) by a SNF (including hospital swing beds providing Part A and Part B services), comprehensive outpatient rehabilitation facility (CORF) or home health agency (HHA). The NOMNC also provides the beneficiary with their appeal rights for the termination of services. The NOMNC must be delivered to the member or the member's authorized representative in accordance with CMS guidelines and at least two days prior to discharge (or the next to the last time services are furnished in the case of CORF or HHA services).

When Molina makes a determination that the member's continued services are no longer skilled and discharge is appropriate, a valid NOMNC is sent to the contracted provider (SNF, CORF, or HHA) for delivery with a designation of the last covered day. Contracted providers are responsible for delivering the NOMNC on behalf of Molina to the member or member representative and for obtaining signature(s) in accordance with CMS guidelines. The contracted provider must provide Molina with a copy of the signed NOMNC. If the member appeals the discharge to the Quality Improvement Organization (QIO), the contracted provider must also provide the QIO with a signed copy of the NOMNC and all relevant clinical information. The member cannot be held liable for any

care (aside from any applicable deductibles or copayments) without proper notification that includes their appeal rights located in the NOMNC and if the member exercises their appeal rights, not before the appeal process with the QIO is complete. If the QIO's decision is favorable to the member, the member cannot be held liable until a proper NOMNC is issued and the member is given their appeal rights again. Failure of the contracted provider to complete the notification timely and in accordance with CMS guidelines or to provide information timely to the QIO may result in the assignment of provider liability. Members cannot be held responsible for the contracted provider's failure to follow the terms of the relevant Provider Agreement or the Provider Manual.

A NOMNC is not issued in the following instances:

- When services are reduced (e.g., when a member is receiving physical therapy and occupational therapy from a home health agency and only the occupational therapy is terminated);
- When the member moves to a higher level of care (e.g., from home health to SNF);
- When the member exhausts their Medicare benefit;
- When the member terminates services on their own initiative;
- When the member transfers to another provider at the same level of care (e.g., a move from one SNF to another while remaining in a Medicare-covered stay); or
- When the provider terminates services for business reasons (e.g., the member is receiving home health services but has a dangerous animal on the premises).

Coordination of Care and Services

Molina HCS Staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Molina's Integrated Care Management (ICM) program via assessment or referral such as self-referral, Provider referral, etc. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

Molina staff provide an integrated approach to care needs by assisting Members with identification of resources available to the Member such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Providers must offer the opportunity to provide assistance to identified Members through:

- Notification of community resources, local or state funded agencies

- Education about alternative care
- How to obtain care as appropriate

Continuity of Care and Transition of Members

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

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

For additional information regarding continuity of care and transition of Members, please contact Molina at: (800) 526-8198.

Continuity and Coordination of Provider Communication

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

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is or receiving or may be in need of receiving community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

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

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or childcare givers
- Psychologists, social workers, family protection workers, or family protection specialists

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

Child Abuse

Link to Department of Social Services: https://www.cdss.ca.gov/reporting/report-abuse/child-protective-services/report-child-abuse

Imperial County: (760)-337-7750

Los Angeles County:
(800)-540-4000 – Within CA
(213)-639-4500 – Outside CA
(800)-272-6699 – TDD

Online Reporting: https://reportChildAbuseLA.org

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

Sacramento County:
(916)-875-5437

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

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

Adult Abuse

Imperial County:
Adult Protective Services
Phone: (760) 337-7878
https://www.molinahealthcare.com/

San Bernardino County:
Adult Protective Services
24- Hour Hotline

Phone: (877) 565-2020
http://hss.sbcounty.gov/daas/programs/APS.aspx

San Diego County:
Adult Protective Services
Phone: (800) 339-4661
Online submission: www.AISWebReferral.org
https://dcfas.saccounty.net/Pages/Home.aspx

Sacramento County:
Adult Protective Services
Phone: (916) 874-9377
https://dcfas.saccounty.net/SAS/Pages/Adult-Protective-Services/SP-Adult-Protective- Services.aspx

Los Angeles County:
Adult Protective Services
24-Hour Abuse Hotline: (877) 477-3646
https://wdacs.lacounty.gov/services/older-dependent-adult-services/adult-protective-services-aps/

Riverside County:
Adult Protective Services
Hotline: (800) 491-7123
https://rivcodpss.org/report-abuse/elder-and-dependent-adult-abuse

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

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

Primary Care Providers

Molina provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina.

Molina's Medicare Members are required to see a PCP who is part of the Molina Medicare Network. Molina's Medicare Members may select or change their PCP by contacting Molina's Member Contact Center.

Specialty Providers

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

Referrals to specialty care outside the network require prior authorization from Molina. Molina will assist in ensuring access for second opinions from network and out of network Providers as well, as applicable.

Care Management (CM)

The Integrated Care Management Program (ICM) provides care coordination and health education for disease management, as well as identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals. Care Management focuses on the delivery of quality, cost-effective, and appropriate health care services for Members. Members may receive health risk assessments that help identify physical health, behavioral health, medication management problems, and social determinants of health to target high-needs Members who would benefit from more intensive support and education from a case manager. Additionally, functional, social support and health literacy deficits are assessed, as well as safety concerns and caregiver needs.

1. **The role of the Case Manager includes:**
    - Coordination of quality and cost-effective services
    - Appropriate application of benefits
    - Promotion of early, intensive interventions in the least restrictive setting of the Member's choice
    - Assistance with transitions between care settings and/or Providers
    - Provision of accurate and up-to-date information to Providers regarding completed health assessments and care plans
    - Creation of ICPs, updated as the Member's conditions, needs and/or health status change
    - Facilitation of Interdisciplinary Care Team (ICT) meetings, as needed
    - Promote utilization of multidisciplinary clinical, behavioral, and rehabilitative services
    - Referral to and coordination of appropriate resources and support services, including but not limited to Long Term Services & Supports (LTSS)
    - Attention to Member preference and satisfaction

- Attention to the handling of Protected Health Information (PHI) and maintaining confidentiality
- Provision of ongoing analysis and evaluation of the Member's progress towards ICP adherence
- Protection of Member rights
- Promotion of Member responsibility and self-management

2. **Referral to Care Management may also be made by the following entities:**
   - Member or Member's designated representative(s)
   - Member's Primary Care Provider
   - Specialists
   - Hospital Staff
   - Home Health Staff
   - Molina Staff

Dual Eligible Members – Special Needs Plan (SNP) Model of Care and 3-Way Contract

The Model of Care is the framework for care management processes and systems that enable coordinated care for our Dual Eligible Special Needs Plan (D-SNP) Members, while the State's 3-way contract guides the coordination for Molina Members enrolled under the Medicare-Medicaid Plan (MMP). The Model of Care includes descriptions of SNP population (including health conditions), Care Coordination, Provider Network and Quality Measurement and Performance Improvement.

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

2. **Care Management Goals** – Utilization of Molina's extensive network of primary Providers, specialty Providers and facilities, in addition to services from the Molina ICT, will improve Molina Members access to essential services such as physical health, behavioral health and social services. Molina demonstrates its compliance with this goal using the following data to see annual improvement compared to benchmarks:
   a. Reports showing availability of services by geographic area
   b. Number of Molina Members utilizing the following services:
      - Primary Care Provider (PCP) Services

- Specialty (including Behavioral Health) Services
- Inpatient Hospital Services
- Skilled Nursing Facility Services
- Home Health Services
- Behavioral Health Facility Services
- Durable Medical Equipment Services
- Emergency Department Services
- Supplemental transportation benefits
- LTSS

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

3. **Access to quality affordable health care**. Molina focuses on delivering high quality care. Molina has an extensive process for credentialing network Providers, ongoing monitoring of network Providers and peer review for quality of care complaints. Molina maintains recommended clinical practice guidelines that are evidence based and nationally recognized. Molina regularly measures Provider adherence to key provisions of its clinical practice guidelines. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:
    a. HEDIS® report of percent Providers maintaining board certification
    b. Serious reportable adverse events report
    c. Annual report on quality of care complaints and peer reviews
    d. Annual PCP medical record review
    e. Clinical Practice Guideline Measurement Report
    f. Licensure sanction report review
    g. Medicare/Medicaid sanctions report review

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

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

a. Medicare Health Outcomes Survey (HOS)
b. Chronic Care Improvement Program Reports

5. **Members will have an assigned point of contact for their coordination of care**. According to Member's needs and/or preferences, this coordination of care point of contact may be their Molina Network PCP or Molina Case Manager. Care will be coordinated through a single point of contact who interact with the ICT to coordinate services and ICP reviews/attestations, as needed.

6. **Improved transitions of care across health care settings, Providers, and health services.** Molina has programs designed to improve transitions of care. Authorization processes enable Molina staff to become aware of transitions of care as they occur. Molina case managers work with Members, their caregivers, authorized representative(s) and/or their Providers to ensure all are aware of the transition episode, address risk associated with transition needs, and assist with planning, preparation and follow up care post transition. Molina's transition of care program provides follow-up telephone calls or face-to-face visits to Members while the Member is in the hospital, when possible, and/or after hospital discharge to make sure that they received and are following an adequate discharge plan. The purpose is to establish a safe discharge plan, ensure the Members have an understanding on how to manage their condition and are able to follow the prescribed discharge plan once they are home. The Molina case manager will work with the Member to ensure they have scheduled a follow up physician appointment, filled all prescriptions, understand how to administer their medications and have received the necessary discharge services such as home health care, durable medical equipment/supplies and/or physical therapy. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement:
    a. Transition of Care Data
    b. Re-admission within 30 Days Report
    c. Provider adherence to notification requirements
    d. Provider adherence to provision of the discharge plan

7. **Improved access to preventive health services.** Molina expands the Medicare preventive health benefit by providing annual preventive care visits at no cost to all Members. This allows PCPs to coordinate preventive care on a regular basis. Molina uses and publicizes nationally recognized preventive health schedules to its Providers. Molina also makes outreach calls to Members to remind

them of overdue preventive services and to offer assistance with arranging appointments and providing transportation to preventive care appointments.

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

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

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

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

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

   ii. Care Review Clinicians (LVN/RN) – Assess, authorize, coordinate, and evaluate services, including those provided by specialists and therapists, in conjunction with

the Member, Providers and other team members based on Member's needs, medical necessity and predetermined criteria.

iii. Case Managers (CM) (comprised of disciplines such as Registered Nurses, Licensed Vocational/practical Nurses, Social Workers, Gerontologists and other health professionals with appropriate background and experience serving vulnerable populations) – assessing, coordinating, triaging and evaluating services in conjunction with the Member, Providers and other team members based on Member's assessed needs and preferences. The CM supports Members, caregivers, authorized representative(s) and Providers which may include facilitation of information retrieval from ancillary Providers, consultants, and diagnostic studies for development, implementation and/or revision of the ICP. The CM continues to work with the Member to identify and address issues regarding Member's physical health, behavioral health, LTSS and social needs; and maintains and updates the ICP and assists in the coordination of services. Updates to the ICP are communicated by the CM to the Member, Provider and participants of the ICT based on member preference.

iv. Health Manager – Serves as a resource for Members and Molina staff members regarding Health Management Program information, educates Members on how to manage their condition. Assists members with addressing physical health, behavioral health, functional and cognitive barriers.

v. Transitions of Care Coach – (Comprised of disciplines such as Registered Nurses, Licensed Vocational/practical Nurses (LVN)/ Licensed Practical Nurses (LPN), Social Workers, Gerontologists and other health professionals with appropriate background and experience serving vulnerable populations.) – The Transitions Coach functions as a facilitator of interdisciplinary collaboration across the transition, engaging the Member, authorized representative(s) and caregivers, facility, and Providers to participate in the formation and implementation of an ICP including interventions to mitigate the risk of re-hospitalization. The primary role of the Transitions staff is to follow the Member closely for up to 30 days post

discharge to ensure a safe transition to the least restrictive most inclusive setting of the Member's choice and to encourage self- management and direct communication between the Member and Provider(s).

vi. Community Connectors/Health Workers – the Community Connectors are community health workers who act as Case Manager Extenders who assist the member in navigating their healthcare needs and connect them to community-based resources, education, advocacy, and social support. Community Connectors are members of the community in which they serve and therefore understand the community's culture, language, and norms. They may assist members with housing, food, clothing, heating, transportation, scheduling appointments, medication refills, obtaining DME and identifying community advocates for eligibility/financial needs.

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

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

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

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

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

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

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

C. **Quality Improvement Team** that develops, monitors, evaluates, and improves the Molina Quality Improvement Program. QI Team is comprisedof the following positions:

i. QI Specialist – Coordinate implementation of QI Program, gatherinformation for QI Program reporting and evaluations, provide analysis of QI Program components.

ii. QI Managers/Directors – Development and oversight of QI Program which includes program reporting and evaluation to identify and address opportunities for improvement.

iii. HEDIS® Specialist – Gather and validate data for HEDIS® reporting.

iv. HEDIS® Manager – Oversight and coordination of data gathering and validation for HEDIS® reporting, provide and interpret HEDIS® reports, provide preventive services missing services report.

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

E. **Behavioral Health Team** has Molina employed health specialists to assist in behavioral health care issues:

i. Psychiatrist Medical Director – Responsible for oversight of the development and integrity of behavioral health aspects of Molina's Healthcare Services and Quality Improvement programs. Resourcefor Integrated Care Management and Utilization Management Teams and Providers regarding Member's behavioral health care needs and care plans. Develops and monitors usage of behavioral health related medical necessity criteria and clinical practice guidelines.

F. **Pharmacy Team** has employed pharmacy professionals that administer the Part D benefit and assist in administration of Part B pharmacy benefits.

i. Pharmacy Technician – Serves as point of contact for Memberswith questions about medications, pharmacy processes, and pharmacy appeals and grievances.

ii. Pharmacist – Provide authorizations for Part D medications. Provide oversight of pharmacy technician performance, resource for Care Management Teams, other Molina staff and Providers, provide review of post discharge medication changes, review Member medication lists and report data to assure adherence and safety, interact with Members and Providers to discuss medication lists and adherence.

G. **Healthcare Analytics Team**

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

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

H. **Health Management Team** is a Molina care team that provides multiple services to Molina's Members. This team provides population-based Health Management Programs for low risk Members identified with asthma and depression. The Health Management team is comprised of the following positions:

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

I. **Nurse Advice Line Team** – a live Registered Nurse is available to receive inbound calls from Members and Providers with questions about medical care and after-hours issues that need to be addressed, give protocol based medical advice to Members and direct after-hours transitions in care. The Nurse Advice Line is available 24 hours / 7 days a week for Members.

J. **Interdisciplinary Care Team**

i. Composition of the Interdisciplinary Care Team (ICT): ICT participants are determined by Member preferences or identifiedneeds and inclusion decisions are made collaboratively and withrespect to the Member's needs and rights to self-direct care, as applicable. Family members and caregiver participation is encouraged and promoted, with the Member's permission. Members are educated about the ICT process during the assessment and provided instruction on how to access an ICT team member and how to request a formal ICT meeting. The CM provides invitations either verbally or in writing to ICT participants and the Member and their PCP are encouraged to participate. The Member may opt out of the ICT meeting and/or choose to limit the role of the participants including caregivers or other Providers.

Collaborators, based on Member preferences and needs may include, but are not limited to:

- Caregiver/Member Representative(s) (if applicable)
- PCP, Nurse Practitioner (NP), Physician Assistant (PA)
- Case Manager
- Molina Medical Director

- Other Molina staff such as, Social worker
- Behavioral Health
- Pharmacist, as needed
- Molina Transitions of Care staff
- Hospitalist/Discharge Planner or SNF/Long-Term Acute Care Facility Teams
- Molina Community Connectors
- Specialty Providers
- Home Health Providers
- Behavioral Health Providers
- Case Managers from County Agencies
- Certified Outpatient Rehabilitation Staff
- Behavioral Health Facility Staff
- Renal Dialysis Center Staff
- Out of Network Providers or Facility Staff (until a member's condition or the state of the Molina Network allows safe transfer to network care)

ii. ICT Operations and Communication: The Member's assigned PCP and/or the Molina Case Manager will facilitate and present the majority of the Member's case during the formal ICT meeting. The PCP will regularly (frequency depends on the Member's medical conditions and status) address the Member's medical conditions, develop appropriate treatment plans, request consultations, evaluations, and care from other Providers both within and, when necessary, outside the Molina Network. The Molina Case Manager will work with the Member, Member representative(s) and/or Provider(s) in completing assessments, developing the ICP and individualized care goals. The PCP is expected to review the Member's individualized care plan (ICP) at creation and every update thereafter. Molina will ensure each Member's PCP has completed the ICP review by tracking and collecting the PCP ICP attestation forms or when consulting the PCP during informal ICT or formal ICT meeting.

iii. The Molina Case Manager will be involved during assessments, ICP creation and follow-up, transitions of care between settings, routine case management follow-up, and significant changes in the Member's health status. In addition, the Member may be referred to

Molina's ICM program from other Molina Staff (i.e. UM staff, Pharmacists, requests for assistance from PCPs, requests for assistance from Members/caregivers, etc.) when Member needs warrant. Transitions in care and significant changes in health statusthat need follow-up will be identified when services requiring prior authorization are requested by the Member's PCP or other Providers such as inpatient admits (signaling a transition in care or complex medical need). The PCP and ICT will decide when additional ICT meetings are necessary and will schedule them on "as needed" basis.

iv. The ICT will hold regular meetings for Members with complex health care needs and/or complex transition issues. Members will be chosen for case conferences based on need as identified by theMolina Case Manager, when referred by their Provider or at the request of the Member/representative/caregiver. All participants of the ICT will be invited to the case conference. The Molina Case Manager will provide a case conference summary for each Membercase discussed, when requested by an ICT participant. The summary is then reviewed with the Member to ensure that they are comfortable with the ICP. The ICP is updated with the Member agreement based on the case conference recommendations in alignment with Providers' treatment plans. Case conference summaries will be provided to all applicable ICT participants as determined by the Member or their representative upon request.

v. Communication between ICT participants will be compliant with allapplicable HIPAA regulations and will occur in multiple ways including:
    - The Molina Case Manager may facilitate sharing of Member's health and LTSS records from ICT Providers before, during, andafter transitions in care settings and during significant changes in the health status of Members, for those health services that require prior authorization, or during the course of regular care management activities.
    - Through consultations among those involved in the Member's care, as warranted, county BH Case Managers, social workers, psychiatrists, home health workers, PCPs, Molina medical directors, pharmacists, dieticians, medical specialists, LTSS Providers and

agencies, family members, authorized representative(s) and other caregivers.
- Case conference summaries available to all Members and active participants of the ICT based on Member preference.
- Updated ICPs are reviewed and shared with participants of the ICT as often as determined by regulatory requirements, with significant changes in health status, or at minimum annually by clinical Molina staff in conjunction with annual Health Risk Assessments.

10. **Provider Network** - Molina maintains a network of Providers and facilities that has a special expertise in the care of dual eligible Members. This population has a disproportionate share of physical and mental/behavioral health disabilities. Molina's network is designed to provide access to medical care for this population.

    Molina's network has facilities with special expertise to care for its Membersincluding:

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

    Molina has a large community-based network of medical and ancillary Providers with many having special expertise including:

    - Primary Care Providers – Internal Medicine, Family Medicine, Geriatric
    - Medical Specialists (all medical specialties) including specifically Orthopedics, Neurology, Physical Medicine and Rehabilitation,

Cardiology, Gastroenterology, Pulmonology, Nephrology, Rheumatology, Radiology and General Surgery.
- Mental/Behavioral Health Providers – Psychiatry, clinical psychology, Masters or above level licensed clinical social work, certified substance abuse specialist.
- Ancillary Providers – Physical therapists, occupational therapists, speech/ language pathology, chiropractic, podiatry.
- Nursing professionals – Registered nurses, nurse Providers, nurse educators.

Molina has a credentialing program to ensure all network Providers meet clearly defined criteria and standards. The credentialing program outlines criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners and facilities for participation in the Molina network. These criteria have been designed to assess a Provider's ability to deliver care. The credentialing program 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. Providers must be recredentialed every 36-months.

The Member's PCP is primarily responsible for determining what medical services a Member needs. For Members receiving treatment primarily through specialist physician, the specialist may be primarily responsible for determining needed medical services. The PCP is assisted by the Molina Care Management Team, medical specialty consultants, ancillary Providers, mental/behavioral health Providers and Members or their caregivers in making these determinations. For Members undergoing transitions in health care settings, facility staff (hospital, SNF, home health, etc.) may also be involved in making recommendations or assisting with access to needed services.

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

- Assuring that services requiring prior authorization are processed and

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

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

11. **Model of Care Training -** All contracted Primary Care and key high-volume Specialty Providers who have been identified as routinely directly or indirectly facilitating and/or providing Medicare Part C or D benefits for Molina Members will be required to complete the Model of Care training and provide attestation of training completion. Providers will have access to the Model of Care training via the Molina website. Providers may also participate in web-based or in person training sessions on the Model of Care trainings. Molina will issue a written request to Providers to participate in Model of Care training. The Molina Provider Services department will identify key groups and may conduct specific in-person or web-based trainings with those groups. The development of Model of Care training materials will be the responsibility of a designated Molina Services Program Director or Medical Director. Implementation and oversight of completion of training will be the responsibility of a designated Molina Compliance staff (employees) and a designated Molina Provider Services staff (Providers). Employees will be required to complete training or undergo disciplinary action in accordance with Molina policies on completion of required training.

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

    a. Molina utilizes state of the art telephonic communications systems for telephonic interaction between Molina staff and all other stakeholders withcapabilities for call center queues, call

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

b. For communication of a general nature Molina uses newsletters (Provider and Member), the Molina website and blast fax communications (Providers only). Molina may also use secure web-based interfaces for Member assessment, staff training, Provider inquiries and Provider training.
c. For communication between participants of the ICT, Molina has available audio conferencing and audio video conferencing (Molina staff only). Most regular and ad-hoc ICT meetings will be held on a face-to-face basis with PCPs, other Providers and Member/caregivers joining via audio conferencing as needed.
d. Written and fax documentation from Members and Providers (clinical records, appeals, grievances) when received will be routed through secure mail room procedures to appropriate parties for tracking and resolution.
e. Email communication may be exchanged with Providers and CMS.
f. Direct person-to-person communication may also occur between various stakeholders and Molina.
g. Molina Quality Improvement Committees and Sub-Committees will meet regularly on a face-to-face basis with Committee members not able to attend in person attending via audio conferencing.

Tracking and documentation of communications occurs utilizing the following:

a. The QNXT call tracking system will be used to document all significant telephonic conversations regarding inquiries from Members/caregivers and Providers. All telephonically received grievances will be documentedin the QNXT call tracking system. QNXT call tracking allows storage of arecord of inquiries and grievances, status reporting and outcomes reporting.
b. Communication between ICT participants and/or stakeholders will be documented in the Care Management electronic

platform. This documentation allows tracking and archiving of discussions. Written meeting summaries may be used when issues discussed are not easily documented using the electronic means documented above.

c. Written and faxed communications when received are stored in an electronic document storage solution and archived to preserve the data. Written documents related to appeals and grievances result in a call tracking entry made in QNXT call tracking when they are received allowing electronic tracking of status and resolution.
d. Email communication with stakeholders is archived in the Molina email server.
e. Direct person-to-person communication will result in an electronic care or utilization management platform call tracking entry or a written summary depending on the situation.
f. Molina Committee meetings will result in official meeting minutes that will be archived for future reference.

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

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

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

q. Case Management Satisfaction Survey

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

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

Molina will submit CMS required public reporting data including:

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

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

a. Audits of health information for accuracy and appropriateness
b. Member/caregiver education for frequency and appropriateness
c. Clinical outcomes
d. Mental/Behavioral health/psychiatric services utilization rates
e. Complaints, grievances, services, and benefits denials
f. Disease management indicators
g. Disease management referrals for timeliness and appropriateness
h. Emergency room utilization rates
i. Enrollment/disenrollment rates
j. Evidence-based clinical guidelines or protocols utilization rates
k. Fall and injury occurrences
l. Facilitation of Member developing advance directives/health proxy
m. Functional/ADLs status/deficits
n. Home meal delivery service utilization rates
o. Hospice referral and utilization rates
p. Hospital admissions/readmissions
q. Hospital discharge outreach and follow-up rates
r. Immunization rates

s. Medication compliance/utilization rates
t. Medication errors/adverse drug events
u. Medication therapy management effectiveness
v. Mortality reviews
w. Pain and symptoms management effectiveness
x. Policies and procedures for effectiveness and staff compliance
y. Preventive programs utilization rates (e.g., smoking cessation)
z. Preventive screening rates
aa. Primary care visit utilization rates
bb. Satisfaction surveys for Members/caregivers
cc. Satisfaction surveys for Provider network
dd. Screening for depression and drug/alcohol abuse
ee. Screening for elder/physical/sexual abuse
ff. Skilled nursing facility placement/readmission rates
gg. Skilled nursing facility level of care Members living in the community having admissions/readmissions to skilled nursing facilities
hh. Urinary incontinence rates
ii. Wellness program utilization rates

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

14. **Care Management for the Most Vulnerable Subpopulations** – Molina identifies the most vulnerable Members as those who may have experienced a change in health status, transition of care setting, a diagnosis that requires extensive use of resources or those who need help navigating the health care system due to inadequate social determinants of health. Molina's most vulnerable population includes Members who may be at imminent risk of:
    - An emergency department visit
    - An inpatient admission
    - Institutionalization related to environmental and/or social issues
    - Transferring to a home or community setting but are currently institutionalized
    - Facing an imminent loss of current living arrangement

    Molina identifies the following vulnerable sub-populations through:

- Historical data
- The assessment process
- Monitoring of utilization activity
- Member or family report
- Provider referral

The needs of the most vulnerable population are met within the Model of Care by early identification and higher stratification/priority in the Molina ICM Program. These Members are managed more closely and frequently by Molina's Case Manager and the ICT, as warranted, based on Member's needs and preferences. Close monitoring ensures that Members receive all necessary services and care plans are updated timely and adequately before, during and after transitions in health care settings or changes in health care status.

7. LONG TERM CARE AND SERVICES

Molina Duals Options Members have access to a variety of Long-Term Services and Supports (LTSS) to help them meet daily needs for assistance and improve quality of life. LTSS benefits are provided over an extended period, mainly in Member homes and communities, but also in facility-based settings such as nursing facilities as specified in his/her Individualized Care Plan. Overall, Molina's care team model promotes improved utilization of home and community-based services to avoid hospitalization and nursing facility care. Molina case managers will work closely with LTSS centers and staff to expedite evaluation and access to services.

LTSS includes all of the following:

- Community-Based Adult Services (CBAS)
- In-Home Supportive Services (IHSS)
- Multipurpose Senior Services Program (MSSP)
- Long-Term Care, Custodial Level of Care in a Nursing Facility

Molina Duals Options program available to members provides seamless coordination between medical care, LTSS, and mental health and substance use benefits covered by Medicare and Medi-Cal. Much of this coordination requires stronger partnership between Molina and county agencies that provide certain LTSS benefits and services. The MOU between Molina and county agencies delineates roles and responsibilities, and processes for referrals and will serve as the foundation for such coordination efforts.

a. CBAS

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

CBAS services allow Members to receive nursing and social services, therapies, personal care, a meal, and case management in one central location. Additional services such as physical therapy, occupational therapy, speech therapy, mental health services, nutritional counseling and transportation may be available to Members based on their Individualized Care Plans.

To be eligible to receive CBAS services, one of the following

criteria's must bemet:

- Nursing facility level A eligible
- Organic, acquired or traumatic brain injury or chronic mental health
- Alzheimer's disease or other dementia stage 5,6,7
- Mild cognitive impairment, including Moderate Alzheimer's stage 4
- Developmental disability
- A physician, nurse practitioner or other health care Provider has within his/her scope of practice requested ADHC services
- Member must need assistance or supervision with two (2) or more of the following activities of daily living: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene; or one (1) listed before and one (1) of the following activities of daily living: money management, accessing resources, meal preparation or transportation

What services are included in CBAS?
Members may receive the following core services:

- Professional nursing
- Social and/or personal care
- Therapeutic activities
- One (1) meal offered per day

Molina case managers will work closely with CBAS centers and staff to expedite evaluation/access to services. Members may also receive any of the following additional services as specified in his/her Individualized Care Plan:

- Physical therapy
- Occupational therapy
- Speech therapy
- Behavioral health services
- Registered dietitian services
- Transportation to/from CBAS center and place of residence

How to refer Members in need of CBAS services:

- Complete & fax CBAS Request for Services Form at: (800) 811-4804
- For more information or if you have any questions, please call MHC Utilization Management Department at: (844) 557-8434 or Member Services Department at: (855) 665-4627.

b. IHSS

In-Home Supportive Services (IHSS) is a California program that provides in- home care for Members who cannot safely remain in their own homes without assistance. To qualify for IHSS, Members must be over sixty-five (65) years of age, or disabled, or blind. By providing in-home assistance to low income aged and disabled individuals, the IHSS program prevents premature nursing home or board and care placement and allows people to remain safely in their own homes and communities.

IHSS is covered as a Medi-Cal benefit, and Molina Healthcare of California coordinates IHSS benefits for eligible enrollees through county IHSS agencies.

IHSS consumers continue to self-direct their care by hiring, firing, and managing their IHSS workers.

County social services agencies conduct the IHSS assessment and authorization processes, including determining IHSS hours. The current fair hearing process for IHSS remains the same.

What services are included in IHSS?

- Housecleaning
- Meal preparation and clean-up
- Laundry
- Grocery shopping and errands
- Personal care services (bowel/bladder care, bathing, grooming, dressing, and feeding, etc.)
- Paramedical services (help with injections, wound care, colostomy, and catheter care, etc.)
- Accompaniment to medical appointments
- Protective supervision for persons with cognitive or intellectual disabilities

What is Self-Directed Care?

One of the most noteworthy aspects of the IHSS program is the beneficiaries' ability to self-direct their care. Self-directed care is the process by which the IHSS consumer, who meets the eligibility criteria for IHSS, chooses to hire, train, supervise, and if necessary, fire the personal assistant. In situations where the member is unable to self-direct their care, Molina case managers coordinate with county social workers.

How to refer Molina Members in need of IHSS Services:

- Providers needing to make a referral should call Member Services at: (855) 665-4627 or the Case Management department at: (844) 203-4287 and follow the prompts, or email MHCCaseManagement@MolinaHealthcare.com and request assistance in referring the Member for IHSS and other community resources.
- Members can also call or visit their local County Social Services agency to verify eligibility and begin the application process. The Health Certification Form will be sent to the Member by the county social worker

It is important to note that the application process cannot continue until the physician has completed it.

a. San Diego County (Health & Human Services Agency): (800) 339-4661
b. Riverside County (Dept. of Public Social Services): (888) 960-4477
c. San Bernardino County (Dept. of Aging and Adult): (877) 800-4544
d. Los Angeles County (Dept. of Public Social Services): (888) 944-4477

c. MSSP

Multipurpose Senior Services Program (MSSP) provides social and health care management for frail elders who are eligible for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care.

Molina Members may be eligible for MSSP if they are sixty-five (65) years of age or older, live within an MSSP sites service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP site staff makes this certification determination based upon Medi-Cal criteria for placement.

What services are included in MSSP?

- Care management
- Adult day care
- Minor home repair/maintenance
- Supplemental in-home chore, personal care, and protective supervision

services
- Respite services
- Transportation services
- Counseling and therapeutic services
- Meal services
- Communications services

How to refer Molina Members in need of MSSP Services:

MHC Case Management staff monitors and reviews Members to determine appropriate utilization of services and to identify Members who may potentially benefit from the MSSP program.

Providers needing to make a referral should contact our Case Management department at FAX: (562) 499-6105, PHONE: (844) 203-4287 and follow the prompts, or MHCCaseManagement@MolinaHealthcare.com and request assistance in referring the Member for MSSP and other community resources.

The health plan's Case Management staff will make referrals as appropriate and work along with the PCP to work with the MSSP Waiver Case Management Team to coordinate services.

Case Management Process

If the Member is determined to be eligible for program referral to MSSP, MHC Case Manager shall participate in the MSSP Case Management Team, as applicable, to develop a comprehensive case management plan. The Case Manager may assist the MSSP team to ensure timely, effective, and efficiently coordinated services to meet the Member's care plan goals.

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

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

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

SNF care and coordinate health care services for the beneficiary for the entire time they reside in a SNF.

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

8. BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES

Overview

Molina provides a Behavioral Health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty Providers to ensure whole person care. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Behavioral Health inpatient and residential services can be requested by submitting a Prior Authorization form or contacting Molina's Prior Authorization team at: (855)-322-4075 Providers requesting after-hours authorization for these services should utilize Provider Portal or fax submission options. Emergency psychiatric services do not require Prior Authorization. All requests for Behavioral Health services should include the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted Medical Necessity criteria for Prior Authorization reviews. Please see the Prior Authorization subsection found in the Health Care Services section of this Provider Manual for additional information.

Access to Behavioral Health Providers and PCPs

Members may be referred to an in-network Behavioral Health Provider via referral from a PCP or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of, or referral for, any known or suspected Behavioral Health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health service within the scope of their practice. A formal referral form or Prior Authorization is not needed for a Member to self-refer or be referred to a PCP or Behavioral Health Provider.

Members may be referred to PCP and specialty care Providers to manage their health care needs. Behavioral Health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Behavioral Health Providers may identify other health concerns, including physical health concerns, that should be addressed by referring the Member to a PCP.

Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with

a behavioral health Provider prior to discharge.

Interdisciplinary Care Coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Molina's Care Management program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Care Management

Molina's Care Management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and SUD needs. Members with high-risk psychiatric, medical or psychosocial needs may be referred by a Behavioral Health Provider to the CM program.

Referrals to the CM program may be made by contacting Molina at:

Phone: (855) 322-4075
Email: Medicare_CM_Team@MolinaHealthcare.com

Additional information on the CM program can be found in the Care Management subsection found in the Health Care Services section of this Provider Manual.

Responsibilities of Behavioral Health Providers

Molina promotes collaboration with Providers and integration of both physical and behavioral health services in effort to provide quality care coordination to Members. Behavioral Health Providers are expected to provide in-scope, evidence-based mental health and substance use disorder services to Molina Members. Behavioral Health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow Quality standards related to access. Molina provides oversight of Providers to ensure Members are able to obtain needed health services within the acceptable appointment timeframes. Please see the Quality section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Lines

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24/7 year-round. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling the Member Services telephone number listed on the back of their Molina Member ID card.

Behavioral Health Tool Kit for Providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to Behavioral Health HEDIS® Tip Sheets and other evidence-based guidance, and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both primary care and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the “Health Resources” tab on the MolinaHealthcare.com Provider website.

9. MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Evidence of Coverage (EOC). The EOC that is provided to Members annually is hereby incorporated into this Provider Manual. The most current EOC can be accessed via the following link: https://www.molinahealthcare.com/members/ca/en-us/-/media/Molina/PublicWebsite/PDF/members/ca/en-us/Medi-Cal/member-services-guide.pdf.

Refer to Chapter 8 which is titled “Your Rights and Responsibilities”

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

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

Second Opinions

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

10. PROVIDER RESPONSIBILITIES

Nondiscrimination of Health Care Service Delivery

Providers must comply with the nondiscrimination of health care service delivery requirements as outlined in the Cultural Competency and Linguistic Services section of this Provider Manual.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to source of payment. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost sharing from a government-funded program.

Section 1557 Investigations

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

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

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

Online: https://MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Should you or a Molina Member need more information, refer to the Health and Human Services website: https://www.federalregister.gov/

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

It is important for Providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Members and Provider Network.
Maintaining an accurate and current Provider Directory is a State and Federal

regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing (some changes can be made online) as soon as possible, but no less than 30 calendar days in advance, of changes such as, but not limited to:

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

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement.

Please visit our Provider Online Directory at: providersearch.MolinaHealthcare.com to validate your information.

For corrections and updates a convenient Provider Information Data Form can be found at: https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ca/Duals/Provider-Information-Data-Form.pdf.

You can also notify your Provider Services representative if your information needs to be updated or corrected.

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

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax, and fax- back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts the Provider Directory or otherwise impacts its membership or ability to coordinate member care. Providers are required to supply timely responses to such communications.

National Plan and Provider Enumeration System (NPPES) Data Verification

CMS recommends that Providers routinely verify and attest to the accuracy of their

National Plan and Provider Enumeration System (NPPES) data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via: https://nppes.cms.hhs.gov.

Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQs) document published at the following link: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools.

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

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

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

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

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA

- Provider Portal

Electronic Claims Submission Requirement

Molina strongly encourages participating Providers to submit claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically
- Eliminating mailing time and enabling Claims to reach Molina faster

Molina offers the following electronic Claims submission options:

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

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

Provider Portal Claims submission includes the ability to:

- Add attachments to Claims
- Submit corrected Claims
- Easily and quickly void Claims
- Check Claims status
- Receive timely notification of a change in status for a particular Claim
- Ability to Save incomplete/un-submitted Claims
- Create/Manage Claim Templates

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

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will

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

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: www.MolinaHealthcare.com.

Provider Portal

Providers and third-party billers can use the no cost Provider Portal to perform many functions online without the need to call or fax Molina. Registration can be performed online and once completed the easy to use tool offers the following features:

- Verify Member eligibility, covered services and view HEDIS needed services (gaps)
- Claims:
    - Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files
    - Correct/Void Claims
    - Add attachments to previously submitted Claims
    - Check Claims status
    - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
    - Create and manage Claim Templates
    - Create and submit a Claim Appeal with attached files
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization/Service Requests
    - Check status of Authorization/Service Requests
- View HEDIS® Scores and compare to national benchmarks
- View a roster of assigned Molina Members for Primary Care Providers (PCPs)
- Download forms and documents
- Send/receive secure messages to/from Molina

Balance Billing

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 that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance, and deductible amounts.

Member Rights and Responsibilities

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

For additional information please refer to the Member Rights and Responsibilities section of this Provider Manual.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and approved by Molina prior to use.

Please contact your Provider Services Representative for information and review of proposed materials.

Member Eligibility Verification

Possession of a Molina ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- Provider Portal at: provider.MolinaHealthcare.com

Molina Provider Services automated IVR system at (800) 357-0172
For additional information please refer to the Eligibility and Enrollment in Molina Dual Options Plan section of this Provider Manual.

Member Cost Share

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

Health Care Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina's Utilization Management and Care Management programs, including all policies and procedures regarding Molina's facility admission, prior authorization, and Medical Necessity review determination and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of

covered services.

For additional information please refer to the Healthcare Services section of this Provider Manual.

In Office Laboratory Tests

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

Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites at: https://appointment.questdiagnostics.com/patient/confirmation and https://www.labcorp.com/labs-and-appointments.

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

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

Referrals

A referral may become necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers need to document 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.

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care, and hospital emergency room. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Molina except in the case of Emergency Services.

For additional information please refer to the Healthcare Services section of this

Provider Manual.

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

Treatment Alternatives and Communication with Members

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

Pharmacy Program

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

Participation in Quality Programs

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

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

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

Compliance

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

Confidentiality of Member Protected Health Information and HIPAA Transactions

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

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with

Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information please refer to the Medicare Member Grievances and Appeals section of this Provider Manual.

Participation in Credentialing

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

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

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

Delegation

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

Primary Care Provider Responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with Molina
- Triage appropriately
- Notify Molina of Members who may benefit from Care Management
- Participate in the development of Care Management treatment plans

Ensuring Adequate COVID-19 Safety Protocols for Federal Contractors for Subcontracts Over the Simplified Acquisition Threshold of $250,000

(a) **Definition**. As used in this clause "*United States or its outlying areas"* means:

(1) The fifty States;
(2) The District of Columbia;
(3) The commonwealths of Puerto Rico and the Northern Mariana Islands;
(4) The territories of American Samoa, Guam, and the United States Virgin Islands; and
(5) The minor outlying islands of Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Islands, Navassa Island, Palmyra Atoll, and Wake Atoll.

(b) **Authority**. This clause implements Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985).

(c) **Compliance***.* The Provider, a subcontractor, shall comply with all guidance, including guidance conveyed through Frequently Asked Questions, as amended during the performance of this Agreement, for contractor or subcontractor workplace locations published by the Safer Federal Workforce Task Force (Task Force Guidance) at: saferfederalworkforce.gov/contractors/.

(d) **Subcontracts**. The Provider shall include the substance of this clause, including this paragraph (d), in subcontracts at any tier that exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award, and are for services, including construction, performed in whole or in part within the United States or its outlying areas."

11. CULTURAL COMPETENCY AND LINGUISTICS SERVICES

Background

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

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

Nondiscrimination of Health Care Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider Network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR), State Law, and Federal program rules which prohibit discrimination. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top 16 languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, participating Providers or contracted medical groups/Independent Physician Associations (IPA) may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

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

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

Members can mail their complaint to Molina at:
Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Members can also file a civil rights complaint with the U.S. Department of Health and Human Services, OCR. Complaint forms are available at: https://www.hhs.gov/ocr/complaints/index.html.

The form can be mailed to:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Members can also send it to a website through the Office for Civil Rights Complaint Portal, available at: https://www.federalregister.gov/

If you or a Molina Member needs help, call: (800) 368-1019 or TTY/TDD (800) 537-7697.

Should you or a Molina Member need more information, refer to the Health and HumanServices website for: https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities- delegation-of-authority.

Cultural Competency

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

Provider and Community Training

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

Services and/or online/web-based training modules.

Training modules, delivered through a variety of methods, include:

1. Provider written communications and resource materials
2. On-site cultural competency training
3. Online cultural competency Provider training modules.
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement – Ensuring Access

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

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e. Braille, audio, large print), leading to better communication, understanding and Member satisfaction. Online materials found on: https://www.molinahealthcare.com/providers/ca/medicaid/resource/Health-Education-Materials.aspx and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

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

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity, and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
  - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report)
- Applicable national demographics and trends derived from publicly available sources
- Assessment of Provider Network
- Collection of data and reporting for the Diversity of Membership HEDIS® measure

- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at: (855) 322-4075. If Contact Center Representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified language service Provider.

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

Molina offers Video Remote Interpretation (VRI) if a telephonic interpreter will not provide meaningful access for an appointment. VRI can be accessed through any standard smartphone, tablet, or laptop equipped with a webcam. No specific software is needed, and the platform is HIPAA compliant and can be used for telehealth visits as well as in-person appointments. VRI appointments can be requested by calling the Contact Center. Requests should be made 48 hours in advance of an appointment.

Molina offers qualified onsite face-to-face interpreter services to Providers and Members at medical appointments based on complex medical cases. Providers and Members may call our Member and Provider Contact Center to submit a request.

Documentation

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

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by Molina
- Document all Member requests for interpreter services
- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code, and vendor
- Document all counseling and treatment done using interpreter services

- Document if a Member insists on using a family member, friend, or minor as an interpreter, or refuses the use of interpreter services after notification of their right to have a qualified interpreter at no cost

Members Who Are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection, accessible by dialing 711. This connection provides access to the Member & Provider Contact Center, Quality Improvement, Healthcare Services, and all other health plan functions.
Molina strongly recommends that Provider offices make assistive listening devices available for Members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the provider's voice to facilitate a better interaction with the Member.

Molina will provide face-to-face service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made three business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via Molina Member Services.

Nurse Advice Line

Molina provides Nurse Advice Services for Members 24 hours per day, seven days per week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly: English line at: (888) 275-8750, Spanish line at: (866) 648-3537, TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

12. CLAIMS AND COMPENSATION

Payer ID	38333
Provider Portal	provider.MolinaHealthcare.com
Clean Claim Timely Filing	180 Calendar days after the discharge for inpatient services or the Date of Service for outpatient services

Electronic Claims Submission

Molina strongly encourages participating Providers to submit Claims electronically, including secondary Claims. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper Claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Provider Portal.
- Submit Claims to Molina via your regular EDI clearinghouse.

Provider Portal

The Provider Portal is a no cost online platform that offers a number of Claims processing features:

Molina uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the Claims from your clearinghouse

- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may email us at: EDI.Claims@MolinaHealthcare.com for additional support.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within 180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within 180 calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or the Provider Portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims). For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim submission instructions on the Member's Molina ID card.

Providers must bill Molina for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed 30 calendar days from the change.

Required Elements

The following information must be included on every Claim:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges
- Place and type of service code
- Days or units as applicable (anesthesia Claims require minutes)
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI)
- Rendering Provider name as applicable
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- E-signature
- Service Facility Location information

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the Claim.

Paper Claim Submissions

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

Molina Healthcare of California, Inc.
PO Box 2270
Long Beach, CA 90801

Please keep the following in mind when submitting paper Claims:

- Paper Claims should be submitted on original red colored CMS 1500 Claims forms
- Paper Claims must be printed, using black ink

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and UB-04 forms.

Corrected Claims may be submitted electronically via EDI, the Provider Portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims)
- Must be submitted on a standard red and white UB-04 or CMS-1500 Claim form (paper Claims)
- Original Claim number must be inserted in field 64 of the UB-04 or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically
- The appropriate frequency code/resubmission code must also be billed in field 4 of the UB-04 and 22 of the CMS-1500

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms or the UB Editor (Uniform Billing Editor) for UB-04 Claim forms.

Corrected Claims must be sent within 180 calendar days of most recent adjudicated date of the Claim.

EDI (Clearinghouse) Submission

837P

- In the 2300 Loop, the CLM segment (Claim information) CLM05-3 (Claim frequency type code) must indicate one of the following qualifier codes:
  - "1"-ORIGINAL (initial Claim)
  - "7"–REPLACEMENT (replacement of prior Claim)
  - "8"-VOID (void/cancel of prior Claim)
- In the 2300 Loop, the REF *F8 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN)

837I

- Bill type for UB Claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1" "7" or "8" goes in the third digit for "frequency"
- In the 2300 Loop, the REF *F8 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN)

Coordination of Benefits (COB) and Third-Party Liability (TPL)

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

Medicaid Coverage for Molina Medicare Members

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

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

Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

The following is a list of CMS Hospital Acquired Conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
    a. Fractures
    b. Dislocations
    c. Intracranial Injuries
    d. Crushing Injuries
    e. Burn
    f. Other Injuries
6. Manifestations of Poor Glycemic Control
    a. Hypoglycemic Coma
    b. Diabetic Ketoacidosis
    c. Non-ketotic Hyperosmolar Coma
    d. Secondary Diabetes with Ketoacidosis
    e. Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures:

    a. Spine
    b. Neck
    c. Shoulder
    d. Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity:
    a. Laparoscopic Gastric Restrictive Surgery
    b. Laparoscopic gastric bypass
    c. Gastroenterostomy
12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Iatrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a. Total Knee Replacement
    b. Hip Replacement

What this means to Providers:

- Acute IPPS Hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- 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/.

Molina Coding Policies and Payment Policies

Frequently requested information on Molina's Coding Policies and Payment Policies is available on the MolinaHealthcare.com website under the Policies tab. Questions can be directed to your Provider Services representative.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate claims. Molina requires coding of both diagnoses and procedures for all claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System Current Procedural Terminology Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient claims. Inpatient hospital claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Molina utilizes a claims adjudication system that encompasses edits and audits that follow State and Federal requirements as well as administers payment rules based on

generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
    - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit, the professional organization standard may be used.
    - In the absence of State guidance, Medicare National Coverage Determinations (NCD).
    - In the absence of State guidance, Medicare Local Coverage Determinations (LCD).
    - CMS Physician Fee Schedule (RVU) indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA)
- ICD-10 guidance published by the National Center for Health Statistics
- Other coding guidelines published by industry-recognized resources
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines
- Molina policies based on the appropriateness of health care and medical necessity
- Payment policies published by Molina

Telehealth Claims and Billing

Providers must follow CMS guidelines as well as State-level requirements.

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type. Use the telehealth Place of Service (POS) Code 02, which certifies that the service meets the telehealth requirements. By coding and billing a place of service 02 with a covered telehealth procedure code, the Provider is certifying the Member was present at an eligible originating site when the telehealth services were performed. Modifier GQ/GT/95is required when applicable. GQ represents services provided not in real time such as remote patient monitoring or “store-and-forward” of information like photographs. GT represents services provided in real time (such as through video consultations). Modifier 95 is used for commercial insurance in place of GT for a set of specific E&M codes as Medicare limits originating site to rural areas. Place of service 02 (telehealth) indicates that telehealth was the place of service. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

National Correct Coding Initiative (NCCI)

CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. Molina Healthcare, Inc. uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUE) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

Correct coding is required to properly process claims. Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component
- Service or procedure has a technical component
- Service or procedure was performed by more than one physician
- Unilateral procedure was performed
- Bilateral procedure was performed
- Service or procedure was provided more than once
- Only part of a service was performed

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS codes

Molina utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny claims that do not meet Molina's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

Place of Service Codes (POS) are two-digit codes placed on health care professional claims (CMS 1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official UB-04 Data Specifications Manual.

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official UB-04 Data Specifications Manual.

Diagnosis Related Group (DRG)

Facilities contracted to use DRG payment methodology submit Claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate Claim payment.

Molina processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and

secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code NDC

The 11-digit National Drug Code Number (NDC) must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04 or its electronic equivalent.

Providers will need to submit claims with both HCPCS and NDC codes with the exact NDC that appears on the medication packaging in the 0-0-0-digit format (i.e. xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD- 10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Claim Auditing

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

Provider acknowledges Molina's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This sample gives an estimate of the proportion of claims Molina paid in error. The estimated proportion, or error rate, may be projected across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide us, or our designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Timely Claim Processing

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

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the Claim for service as follows:

- 95 percent of the monthly volume of non-contracted "clean" Claims are to be adjudicated within 30 calendar days of receipt
- 95 percent of the monthly volume of contracted Claims are to be adjudicated within 60 calendar days of receipt
- 95percent of the monthly volume of non-clean non-contracted Claims shall be paid or denied within 60 calendar days of receipt

The receipt date of a Claim is the date Molina receives notice of the Claim.

Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at: www.MolinaHealthcare.com or by contacting our Provider Services department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. Dispute overpayment findings.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For members with Commercial COB, Molina will provide notice within 270 days from the claim's paid date if the primary insurer is a Commercial plan. A provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the overpayment.

Claim Reconsideration

Providers requesting a reconsideration of a claim previously adjudicated must request such action within 120 calendar days of Molina's original remittance advice date or longer as stated in the Provider Agreement as the Provider Agreement would supersede.

Reconsiderations are defined as follows:

- Appeals - Written request for reconsideration of a claim related to a complete denial of payment for services.
- Dispute - Written request for reconsideration of the amount paid on a claim after the claim has been adjudicated and payment has been remitted.

All Claim reconsideration's must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider website and the Provider Portal. The form must be filled out completely in order to be processed. Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following documentation:

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

All Appeals and Disputes must be submitted to Molina through one of the following channels:

- Provider Portal: provider.molinahealthcare.com/provider/login
- Mailed to: Molina Contracted Provider Appeals, PO Box 22816, Long Beach, CA 90801
- Faxed to: (562) 499-0610

Please Note: Requests for adjustments of Claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original Claim.

The Provider will be notified of Molina's decision in writing within 60 calendar days of receipt of the Claims Dispute/Adjustment request.

Note: Corrected claims are to be directed through the original claim's submission process, clearly identified as a corrected claim.

All questions pertaining to claim redetermination requests are to be directed to the Provider Contact Center at (885) 665-4627.

Provider Reconsideration of Delegated Claims – Contracted Providers

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

Balance Billing

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 that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance, and deductible amounts. Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts.

Fraud and Abuse

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

Encounter Data

Each Provider, capitated Provider, or organization delegated for Claims processing is required to submit Encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least once per month, and within 60 days from the date of service in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D – Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

Molina has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

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

Molina has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two types of responses:

- First, Molina will provide a 999 acknowledgement of the transmission
- Second, Molina will provide a 277CA response file for each transaction

13. COMPLIANCE

Fraud, Waste and Abuse Program

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which addresses how Molina will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste and abuse prevention and detection along with and the education of appropriate employees, vendors, providers, and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to detect, deter, and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission Statement

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

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a Federal statute that covers fraud involving any Federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent Claim to the U.S. government for payment.

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

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

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

Deficit Reduction Act

The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of 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 whistleblowers

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 Act. 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 payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the Law.

Anti-Kickback Statute – Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other Federal health care programs.

Stark Statute – Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to services provided only by Practitioners, rather than by all health care Providers.

Sarbanes-Oxley Act of 2002 – Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

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

Waste: means health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g., coding) causing unnecessary costs to State and Federal health care programs.

Abuse: means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to State and Federal health care programs, 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 State and Federal health care programs. (42 CFR § 455.2).

Examples of Fraud, Waste and Abuse by a Provider

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

- A physician knowingly and willfully referring a Member to health care facilities in which or with which the physician has a financial relationship (Stark Law).
- Altering Claim forms, electronic Claim forms, and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order

to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

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

- Benefit sharing with persons not entitled to the Member's Medicare and/or Medicaid benefits.
- Conspiracy to defraud State and Federal health care programs.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from and the Member sells the medication to someone else

Review of Provider Claims and Claims System

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

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

performed as authorized.

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

Prepayment Fraud, Waste and Abuse Detection Activities

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

Molina has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare & Medicaid Services (CMS), Federal CMS guidelines, AMA, and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Molina may, at the request of a State program or at its own discretion, subject a Provider to prepayment reviews whereupon Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the Claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at Law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in

Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to Provider's records, all of the Claims for which Provider received payment from Molina is immediately due and owing. If Provider fails to provide all requested documentation for any Claim, the entire amount of the paid Claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment Claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Claims Auditing

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

Provider acknowledges Molina's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that Molina paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of

overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Provider Education

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

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

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available 24 hours a day, seven 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 Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

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

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

Molina Healthcare of California
Attn: Compliance

200 Oceangate, Suite 100
Long Beach, CA 90802
Remember to include the following information when reporting:

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

Suspected fraud and abuse may also be reported directly to CMS Toll Free Phone: 1-800-MEDICARE (1-800-633-4227)

Or

Office of Inspector General
Attn: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

Toll Free Phone: (800) 447-8477

TTY/TDD: (800) 377-4950
Fax (10-page max): (800) 223-8164

Online at the Health and Human Services Office of the Inspector General Website: oig.hhs.gov/FRAUD/REPORT-FRAUD/INDEX.ASP

HIPAA Requirements and Information

HIPAA (Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all Federal and State Laws regarding the privacy and security of Members' Protected Health Information (PHI).

Provider Responsibilities

Molina expects that its contracted Provider will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under State and Federal Law, including:

- 42 C.F.R. Part 2 Regulations
- Health Information Technology for Economic and Clinical Health Act, (HITECH Act)

Applicable Laws

Providers must understand all State and Federal health care privacy Laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of Laws that Providers must comply with. In general, most health care Providers are subject to various Laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. **Federal Laws and Regulations**
    - HIPAA
    - The Health Information Technology for Economic and Clinical Health Act (HITECH)
    - 42 C.F.R. Part 2
    - Medicare and Medicaid Laws
    - The Affordable Care Act

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

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation,

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

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

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
    a. Quality Improvement
    b. Disease Management
    c. Case Management and Care Coordination
    d. Training Programs
    e. Accreditation, Licensing, and Credentialing

Importantly, this allows Providers to share PHI with Molina for our health care operations activities, such as HEDIS® and Quality improvement.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2. (*Please note that the HHS Office for Civil Rights, in coordination with the Substance Abuse and Mental Health Services (SAMHSA), is expected to issue a rule that would implement Section 3221 of the CARES Act and better harmonize the 42 CFR Part 2 confidentiality requirements with HIPAA*.)

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction, and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written Authorizations

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

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law.

Patient Rights

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

1. **Notice of Privacy Practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.
2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.
3. **Requests for Confidential Communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.
4. **Requests for Patient Access to PHI**
   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.
5. **Request to Amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.
6. **Request Accounting of PHI Disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

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

problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

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

HIPAA Transactions and Code Sets

Molina strongly supports the use of electronic transactions to streamline health care administrative activities. Molina Providers are encouraged to submit Claims and other transactions to Molina using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and Encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at: www.MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

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 30 days and should also be reported to Molina within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under

HIPAA and on all claims and encounters submitted to Molina.

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

Molina does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review
- Resolution of an Appeal and/Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® medical records

Business Continuity Plan (BCP)

The Provider will have a documented Business Continuity Plan (BCP) to ensure continuation and recovery of services after a disruption occurs. The BCP will be updated at least annually and approved by the applicable designated representative.

The Provider Business Continuity Plan will include:

- Names and contact information for staff responsible for invoking and managing response and recovery
- Molina notification names and contact information
- Disaster declaration process
- Details of how the services will be recovered and restored
- Details of how the systems and applications supporting the services will be recovered and restored, including recovery of data

The Provider will notify Molina of a disruption to the services or activation of business continuity plans within two hours and will provide Molina with regular updates on the situation and actions taken to resolve the issue, until normal services have been resumed.

The Provider will ensure that its third parties needed to deliver the services have appropriate Business Continuity Plans in place to prevent significant disruption to the services.

The Provider will test the BCP at least annually and document the test results. Provider will make available to Molina, upon request, the results of the most recent test including lessons learned and remediation plans.

The Provider will participate in Molina annual tests upon notification and mutual agreement.

After disruption to services, once normal service has been resumed, the Provider will promptly complete a root cause analysis report and provide it to Molina.

Definitions

Business Continuity Plan: documented procedures that guide organizations to respond, recover, resume and restore to a pre-defined level of operations following a disruption.

Disaster Recovery Plan: a document that defines the resources, actions, tasks and data required to manage the technology recovery effort.

Disaster Declaration: criteria to declare a disaster and the staff authorized to invoke recovery plans to recover and restore Services.

Cybersecurity Requirements

Note: This section (Cybersecurity Requirements) is only applicable to providers who are delegated providers and have been delegated by Molina to perform a health plan function.

1. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by law or any enforcement agency.
2. The following terms are defined as follows:
    I. “Consumer” means an individual who is a State resident, whose Nonpublic Information is in Molina’s possession, custody or control and which Provider maintains, processes, stores or otherwise has access to such Nonpublic Information.
    II. “Cybersecurity Event” means any act or attempt, successful or, to the extent known by Provider, unsuccessful, to gain unauthorized access to, disrupt or misuse an Information System or Nonpublic Information stored on such Information System. The ongoing existence and occurrence of attempted but Unsuccessful Security Incidents shall not constitute a Cybersecurity Event under this definition. “Unsuccessful Security Incidents” are activities such as pings and other broadcast attacks on

Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Molina Nonpublic Information or sustained interruption of service obligations to Molina.

III. "Information System" or "Information Systems" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic Nonpublic Information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.

IV. "Nonpublic Information" means information that is not publicly available information and is one of the following:

(a) business related information of Molina the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Molina;

(b) any information concerning a Consumer that because of the name, number, personal mark, or other identifier contained in the information can be used to identify such Consumer, in combination with any one or more of the following data elements:

(i) social security number;

(ii) driver's license number, commercial driver's license or state identification card number;

(iii) account number, credit or debit card number;

(iv) security code, access code, or password that would permit access to a Consumer's financial account; or

(v) biometric records;

(c) any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a Consumer, that can be used to identify a particular Consumer, and that relates to any of the following:

(i) the past, present, or future physical, mental or behavioral health or condition of a Consumer or a member of the Consumer's family;

(ii) the provision of health care to a Consumer; or

(iii) payment for the provision of health care to a Consumer.

V. "State" means the State of California.

3. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information, as defined herein, that are accessible to, or held by, the Provider. Implementation of the foregoing measures shall incorporate guidance issued by the State Department of Insurance, as appropriate.
4. Provider agrees to comply with all applicable laws governing Cybersecurity Events. Molina will decide on notification to affected Consumers or government entities. Upon Molina's prior written request, Provider agrees to assume

responsibility for informing all such Consumers in accordance with applicable law.

5. In the event of a Cybersecurity Event, Provider shall notify Molina's Chief Information Security Officer of such Cybersecurity Event by telephone and email (as provided below) as promptly as possible, but in no event later than 72 hours from a determination that a Cybersecurity Event has occurred. A follow-up notification shall be provided by mail, at the address indicated below. Notification to Molina's Chief Information Security Officer shall be provided to:
   Molina Chief Information Security Officer

   Telephone: 844-821-1942

   Email: CyberIncidentReporting@molinahealthcare.com

   Molina Chief Information Security Officer

   Molina Healthcare, Inc.
   200 Oceangate Blvd., Suite 100
   Long Beach, CA 90802
6. Upon Provider's notification to Molina of a determination of a Cybersecurity Event, Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation, or, upon written request by Molina, Provider shall complete an investigation pursuant to the following requirements:
   (a) determine whether a Cybersecurity Event occurred;
   (b) assess the nature and scope of the Cybersecurity Event;
   (c) identify Nonpublic Information that may have been involved in the Cybersecurity Event; and
   (d) perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of the Nonpublic Information.
7. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon request of Molina.
8. Provider must provide to Molina the documentation required and requested by Molina in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina in the initial and subsequent notices must include as much of following information known to Provider at the time of the notification:
   (a) the date of the Cybersecurity Event;

(b) a description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Provider, if any;
(c) how the Cybersecurity Event was discovered;
(d) whether any lost, stolen, or breached information has been recovered and if so, how this was done;
(e) the identity of the source of the Cybersecurity Event;
(f) whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
(g) a description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the Consumer;
(h) the period during which the Information System was compromised by the Cybersecurity Event;
(i) the number of total Consumers in the State affected by the Cybersecurity Event;
(j) the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
(k) a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
(l) a copy of Provider's privacy policy and if requested by Molina, the steps that Provider will take to notify Consumers affected by the Cybersecurity Event; and
(m) the name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

In the event provisions of this Section conflict with provisions of any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

14. CREDENTIALING AND RECREDENTIALING

The purpose of the Credentialing Program is to assure the Molina Healthcare and its subsidiaries (Molina) networks consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Molina provider services representative.

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

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

Non-Discriminatory Credentialing and Recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g. Medicaid) in which the Practitioner specializes. This does not preclude Molina from including in its network Practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Type of Practitioners Credentialed & Recredentialed

Practitioners and groups of practitioners with whom Molina contracts must be credentialed prior to the contract being implemented.

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care practitioners who are licensed, certified or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists

- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

HIV/AIDS Specialist

Molina requires Practitioners to submit a complete, signed and dated HIV/AIDS Specialist form to identify appropriately qualified specialists who meet the definition of an HIV/AIDS specialist under California Code of Regulations Section 1374.16 of the Act.

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the Molina network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Practitioners who do not meet the criteria. Molina may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any Practitioner to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to

prove they meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application –** Provider must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within one-hundred-twenty (120) days. Application must include all required attachments.
- **License, Certification or Registration –** Provider must hold a current and valid license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine practitioners are required to be licensed in the state where they are located and the State the member is located.
- **DEA or CDS Certificate –** Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number.
- **Specialty –** Provider must only be credentialed in the specialty in which they have adequate education and training. Provider must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education –** Provider must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training –** Provider must have satisfactorily completed residency programs from accredited training programs in the specialties in which they are practicing. Molina only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three (3) years in length. If the podiatrist has not completed a three (3)-year residency or is not board certified, the podiatrist must have five (5) years of work history practicing podiatry.
- **Fellowship Training –** If the Provider is not board certified in the specialty in

which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.

- **Board Certification –** Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:
    - American Board of Medical Specialties (ABMS)
    - American Osteopathic Association (AOA)
    - American Board of Foot and Ankle Surgery (ABFAS)
    - American Board of Podiatric Medicine (ABPM)
    - American Board of Oral and Maxillofacial Surgery
    - American Board of Addiction Medicine (ABAM)
    - College of Family Physicians of Canada (CFPC)
    - Royal College of Physicians and Surgeons of Canada (RCPSC)
    - Behavioral Analyst Certification Board (BACB)
    - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners –** Practitioners who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five (5) years without any gaps in work history. Molina will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner, if the Practitioner is applying to participate as a Primary Care Physician (PCP), Urgent Care or Wound Care. General Practitioners providing only wound care services do not require five (5) years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants –** In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, it would also be required that the Practitioner providing the supervision and/or oversight be contracted and credentialed with Molina.
- **Work History –** Provider must supply most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the Practitioner must clarify the gap verbally or in writing. The organization will document a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing.
- **Malpractice History –** Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance –** Provider must supply a history of malpractice and professional liability claims and settlement history in accordance

with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.

- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice–** Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations, and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Molina will also verify all licenses, certifications, and registrations in every State where the Practitioner has practiced. At the time of initial application, the Practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
- **Medicare, Medicaid and other Sanctions and Exclusions –** Practitioner must not be currently sanctioned, excluded, expelled or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt Out –** Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File –** Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.

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

- **Medicare Preclusion List –** Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance –** Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioners activities on Molina's behalf. Practitioners maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform –** Practitioner must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of Present Illegal Drug Use –** Practitioner must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions –** Practitioners must disclose if they have ever had any criminal convictions. Practitioners must not have been convicted of a felony or pled guilty to a felony for a health care related crime including but not limited to health care fraud, patient abuse and the unlawful manufacturing, distribution or dispensing of a controlled substance.
- **Loss or Limitations of Clinical Privileges –** At initial credentialing, Practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges –** Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI –** Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare & Medicaid Services (CMS).

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

Molina will notify the Practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification, sanctions or exclusions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

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

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

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

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

The Practitioner must notify the Credentialing department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.
The only items in the file that may be copied by the Practitioner are documents, which the practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application

by telephone, email or mail. Practitioner's rights are published on the Molina website and included in this Provider Manual. Molina will respond to the request within two (2) working days. Molina will share with the Practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Molina Medical Director within two (2) weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than sixty (60) calendar days from the decision. Notification of recredentialing approvals are not required.

Recredentialing

Molina recredentials every Practitioner at least every thirty-six (36) months.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions

Molina monitors the following agencies for Provider sanctions and exclusions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality is identified. If a Molina Provider is found to be sanctioned or excluded, the Provider's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program –** Monitor for individuals and entities that have been excluded from

Medicare and Medicaid programs.

- **State Medicaid Exclusions –** Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED) –** Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List –** Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database –** Molina enrolls all credentialed Practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM) –** Monitor for Providers sanctioned with SAM.

Molina also monitors the following for all Provider types between the recredentialing cycles.

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a Provider's contract based on quality of care or professional conduct, a certified letter is sent to the Provider describing the adverse action taken and the reason for the action, including notification to the Provider of the right to a fair hearing when required pursuant to Laws or regulations.

15. FACILITY SITE REVIEW

The facility site review (FSR) is a comprehensive evaluation of the facility, administration, and medical records to ensure conformance to the California Department of Health Care Services (DHCS) and regulatory agency standards. The review and certification of Primary Care Practitioner (PCP) sites are required for all health plans participating in the Medi-Cal managed care program (Title 22, CCR, Section 56230). The California statute requires that all PCP sites or facilities rendering services to Medi-Cal eligible patients must be certified and compliant with all applicable DHCS standards. Furthermore, facility site reviews are required as part of the credentialing process, according to the provision of Title 22, CCR, Section 53856.

A PCP is defined as a General Practitioner, an Internist, a Family Practitioner, Obstetrician/Gynecologist (OB/GYN) who meets the requirements for PCP, or a Pediatrician who, by contract, agrees to accept responsibility for primary medical care services.

Facility Site Review Process

Effective July 1, 2002, the State of California's Health and Human Services Agency mandated that all County Organized Health Systems (COHS), Geographic Managed Care (GMC) Plans, Primary Care Case Management (PCCM) Plans, and Two-Plan Model Plans use the Full Scope Site Review and Medical Record Review Evaluation Tool.

In efforts to avoid duplication and overlapping of FSR reviews, the Medi-Cal managed care health plans within the county have established systems and procedures for the coordination and consolidation of site audits for mutually shared PCP sites and facilities. One (1) site review conducted by a participating collaborative Medi-Cal managed care health plan will be accepted by other Medi-Cal managed care health plans. This will establish ONE (1) certified FSR and MRR that the participating PCP site will need to pass and be eligible with all the Medi-Cal Health Plans in a given county.

Standardized DHCS Facility Site Review Tool is comprised of three (3) components:

- Facility Site Review Tool
- Medical Record Review Tool
- Physical Accessibility Review Survey

Initial Full Scope Review

All primary care sites serving Medi-Cal managed care Members must undergo an initial site review with attainment of a minimum passing score of eighty percent (80%) on the site review and medical record review. The initial site review is the first onsite inspection of a site that has not previously had a full scope survey, or a PCP site that is returning to the Medi-Cal managed care program and has not had a full scope survey within the

past three (3) years with a passing score. The initial full scope site review survey can be waived by a managed care health plan for a pre- contracted physician site if the physician has a documented proof of current full scope survey, conducted by another Medi-Cal managed care health plan within the past three (3) years. MHC follows the same procedures as for an initial site visit when a PCP relocates or opens a new site.

Subsequent Periodic Full Scope Site Review

After the initial full scope survey, the maximum time period before conducting the subsequent full scope site survey is three (3) years. Managed care health plans may review sites more frequently per local collaborative decision or when determined necessary, based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues.

Medical Record Review

The on-site Practitioner/Provider medical record review is a comprehensive evaluation of the medical records. Molina Healthcare of California (MHC) will provide information, suggestions, and recommendations to assist Practitioners/Providers in achieving the standards. All PCPs must complete and pass the medical record review at each practice location. Medical Record Reviews are conducted in conjunction with the Facility Site Review, prior to participating in MHC Provider network and at least every three (3) years thereafter. Ten (10) medical records are reviewed for each physician. Sites where documentation of patient care by multiple PCPs occurs in the same medical record will be reviewed as a "shared" medical record system. Shared medical records are those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of ten (10) records will be reviewed if two (2) to three (3) PCPs share records, twenty (20) records will be reviewed for four (4) to six (6) PCPs, and thirty (30) records will be reviewed for seven (7) or more PCPs.

Physical Accessibility Review Survey (PARS)

In accordance with the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) policy letter12-006, managed care health plans are required to assess the level of physical accessibility of Provider sites, including all primary care physicians, specialists, ancillary Providers and Community-Based Adult Services (CBAS) that serve a high volume of Seniors and Persons with Disabilities (SPD). The PARS tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA). PARS consist of eighty-six (86) criteria that include twenty-nine (29) designated critical access elements. The information provided must, at a minimum, display the level of access results met per Provider site as either Basic Access or Limited Access, and Medical Equipment (and/or Participant Area) Access.

Basic Access demonstrates that a facility site provides access for Members with disabilities to parking, exterior building, interior building, exam room, restrooms, and medical equipment. Unlike the Facility Site Review and Medical Records Review, PARS is an assessment and no corrective action is required.

SCORING

All Primary Care Physicians must maintain an Exempted or Conditional pass on site review and medical record review to participate in MHC Provider network. The evaluation scores are based on standardized scoring mechanism established by DHCS.

Compliance & Corrective Action Plan (CAP) Facility Site Review Score Threshold

Exempted:

- A performance score of ninety percent (90%) or **above without deficiencies** in Critical Elements, Pharmaceutical or Infection Control sections of the review tool
- A Corrective Action Plan is not required

Conditional:

- A performance score of eighty percent to ninety percent (80% - 90%) or ninety percent (90%) and above with deficiencies in Critical Elements, Pharmaceutical or Infection Control sections of the review tool
- A Corrective Action Plan is required

Fail:

- Below eighty percent (80%) performance score
- A Corrective Action Plan is required

Medical Record Review Score Threshold

Exempted:

- A performance score of ninety to one hundred percent (90% to 100%), with all section scores at 80% and above
- A Corrective Action Plan is not required

Conditional:

- A performance score of ninety percent (90%) and above, with one or more section scores below 80%.
- A performance score of eighty to eighty-nine percent (80% to 89%)
- A Corrective Action Plan is required

Fail:

- Below eighty percent (80%) performance score
- A Corrective Action Plan is required

Physicians with an Exempted Pass Score

All reviewed sites that score ninety to one hundred percent (90% to 100%) on the facility site review survey ***without deficiencies*** in Critical Elements, Pharmaceutical or Infection Control sections of the review tool do not need to submit a CAP.

All reviewed sites that score ninety to one hundred percent (90% to 100%) and greater than eighty percent (80%) on each section scores of the medical record review survey

do not need to submit a CAP. Any section score of less than eighty percent (80%) in the medical record review survey requires submission of completed CAP, regardless of the aggregated MRR score.

Physicians with a Conditional Pass Score

A score of eighty to eighty-nine percent (80% to 89%) or ninety percent (90%) and above with deficiencies in Critical Element, Pharmaceutical or Infection Control sections of the review tool must complete and submit a CAP.

- Critical Element CAP must be completed, verified, and submitted within ten (10) calendar days from the date of the review.
- CAP must be completed and submitted within thirty (30) calendar days from the date of the written CAP request

A score of eighty to eighty-nine percent (80% to 89%) of the medical record review survey must complete and submit a CAP. The CAP must be submitted within thirty (30) calendar days from the date of the review.

Physicians with a Not Pass Score

A score of seventy-nine percent (79%) or below and survey deficiencies not corrected within the established CAP timeframes will not have new Members assigned until all deficiencies are corrected and the CAP is closed. The CAP must be completed, submitted timely, fully accepted, and verified or a follow-up visit must be conducted for a focused review with a passing score.

PCPs who do not come into compliance with review criteria and CAP requirements may be removed from the network and have membership reassigned. If the PCP remains in the network, membership panels will be closed until the CAP is completed, all deficiencies are corrected according to the CAP timelines and the PCP will be monitored for subsequent fails.

In compliance to the Department of Health Care Services, Medi-Cal Managed Care Division Policy Letter 20-006, physicians, and sites with Not Pass scores must be notified to all Medi-Cal Managed Care Health Plans in the county.

CAP Extension

No timeline extensions are allowed for Critical Element CAP completion. A physician may request a definitive, time-specific extension period that does not exceed one-hundred-twenty (120) calendar days from the date of the survey findings report and CAP notification. The request shall be submitted through a formal written explanation of the reason(s) for the extension.

Any extension beyond one-hundred-twenty (120) calendar days requires an approval from the Department of Health Care Services and agreed upon by the health plan.

NOTE: AN EXTENSION PERIOD BEYOND ONE-HUNDRED-TWENTY (120)

CALENDAR DAYS TO COMPLETE CORRECTIONS REQUIRES THAT THE SITE BE RESURVEYED PRIOR TO CLOSING THE CAP IN TWELVE (12) MONTHS.

CAP Completion

Physicians or their designees can complete the CAP:

- Review and correct the identified deficiencies in Column Two (2) and Column Three (3) of the CAP form
- Review and implement the recommended corrective actions in Column Four (4) of the CAP form and provide appropriate attachments or documents that address the deficiencies
- Enter the date of completion or implementation of the corrective action in Column Five (5) of the CAP form
- Document specific comments on implemented activities to address and satisfy the corrective action(s) and document a responsible designee's initials in Column Six (6) of the CAP form
- Document the signature and the title of the physician or the designee who is responsible for completing the CAP in Column Seven (7) of the CAP form
- Upon implementation, completion and documentation of the entire corrective action items identified on the CAP form, submit the completed CAP form

CAP Submission

The physician, at his/her discretion, may involve any or all IPAs/Medical Groups or management companies with which the physician is contracted to assist in completion of the CAP. The CAP must be submitted directly to the Site Reviewer of the health plan.

Identification of Deficiencies Subsequent to an Initial Site Visit

Any MHC Director or Manager shall refer concerns regarding Member safety and/or quality of care issues to appropriate Department(s) for necessary follow-up activities.

Member complaints related to physical office site(s) are referred to appropriate MHC Department(s) for investigation that may include performing an unannounced facility site evaluation and subsequent follow-up of any identified corrective actions.

DEPARTMENT OF HEALTH CARE SERVICES (DHCS) REVIEW OF MOLINA HEALTHCARE'S PERFORMANCE OF FACILITY SITE REVIEWS

Review Process

An oversight audit of MHC and contracted physicians and facilities will be conducted by the DHCS.

- These visits may be conducted with or without prior notification from the DHCS

If a prior notification is given, the sites selected by the DHCS for oversight reviews will be contacted to arrange a visit schedule by either the DHCS auditor or MHC.

MHC will provide any necessary assistance required by the DHCS in conducting facility oversight evaluations.

Requirements and Guidelines for Facility Site

Complete and comprehensive requirements, standards, and guidelines are found in

- **Facility Site Review Tool and Facility Site Review Guideline**

Please visit MHC website at: www.MolinaHealthcare.com to review these documents.

Requirements and Guidelines for Medical Record Documentation (applies to both adults and children)

Complete and comprehensive requirements, standards, and guidelines are found in

- **Medical Record Review Tool and Medical Record Review Guideline**

Please visit MHC website at: www.MolinaHealthcare.com to review these documents.

16. DELEGATION

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

1. Utilization Management
2. Credentialing and Recredentialing
3. Sanction Monitoring for employees and contracted staff at all levels
4. Claims
5. Other clinical and administrative functions

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) and will be reviewed by Molina Delegation Oversight Staff for compliance with performance expectations within the timeline and format indicated by Molina.

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also impose administrative and/or financial sanctions or revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

Delegation Criteria

An entity may request Credentialing, Utilization Management or Claims delegation from Molina through Molina's Delegation Oversight Director/Manager or through their Contract Manager. Molina will request a potential delegate to submit policies and procedures for review and will schedule a time for an onsite pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate is based on the Medical

Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation of the function.

Sanction Monitoring

All sub-contractors of Molina are required to show proof of processes to screen staff and employees at all levels against Federal exclusions lists. Screening must be done prior to the employee/staff's hire date and occur monthly thereafter. Molina will include a Sanction Monitoring pre-assessment audit with all other pre-assessment audits, any time a function(s) is/are being considered for delegation.

Sanction Monitoring functions may be delegated to entities that meet Molina criteria. To be delegated for sanction monitoring functions, Providers must:

- Pass Molina's sanction monitoring pre-assessment and annual audits, which are based on CMS and OIG standards.
- Demonstrate that employees and staff are screened against Office of Inspector General (OIG) and System for Award Management (SAM) sanction lists prior to hire dates, and monthly thereafter.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are self-reported by a delegated entity or identified by Molina.
- Agree to Molina's contract terms and conditions for sanction monitoring delegates.
- Submit timely and complete Sanction Monitoring delegation reports as detailed in the Delegated Services Addendum or as communicated by Molina to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.
- When staff or employees are identified as having a positive sanction, provide Molina with notification according to Contractual Agreements of the findings and action(s) being taken to ensure sanctioned staff is not providing services to Molina Members.
    - Provide a 90-day advance notification to Molina of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process.
    - In a timely and appropriate manner, respond, cooperate and participate when applicable, in Health Plan, legal and regulatory inquiries and audits.

Credentialing

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

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

- Pass Molina's credentialing pre-assessment and annual audits, which are based on NCQA credentialing standards and applicable State and Federal regulations.
- Have a multi-disciplinary Credentialing Committee who is responsible for review

and approval or denial/termination of practitioners included in delegation.
- Have an ongoing Monitoring process in place that screens all practitioners included in delegation against OIG and SAM, exclusion lists a minimum of every 30 days.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions and applicable accreditation standards for credentialing delegates.
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum or as communicated by Molina to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members.
- Provide a 90-day advance notification to Molina of its intent to sub-delegate and include pre- delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate, and participate when applicable, in Health Plan, legal and regulatory inquiries and audits

Note: At its discretion, Molina may conduct a modified pre-assessment audit if the Provider is an NCQA Certified or Accredited organization. Modification to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions or demonstrate an ability to meet all Health Plan, NCQA, and State and Federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be completed on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, Credentialing Committee Minutes, Ongoing Monitoring documentation, and a process to implement corrective action if issues of non-compliance are identified.

Utilization Management

Utilization Management (UM) functions may be delegated to entities that meet National Committee for Quality Assurance (NCQA) criteria, regulatory and Molina established standards for utilization management functions and processes.

To be delegated for utilization management functions, the potential delegates must at minimum:

- Pass Molina's Utilization Management pre-assessment and annual audits, which are based on regulatory, NCQA UM and Molina established standards and state

and federal regulatory requirements
- Have a multi-disciplinary Utilization Management Committee who is responsible for oversight of the UM program, review and approval of UM policies and procedures and ensuring compliance of the UM processes and decisions
- Have a full time Medical Director responsible for the UM program and holds an unrestricted license to practice medicine in California
- Have internal controls and quality monitoring of work performed by the UM staff
- Correct deficiencies within Molina established timeframes when issues of non-compliance are self-identified, identified by Molina or a state or federal regulatory agency
- Agree to and cooperate with Molina's contract terms and conditions for utilization management delegates
- Submit timely and complete Utilization Management delegation reports in a format and frequency determined by Molina
- Comply with all applicable accreditation and regulatory standards and applicable Federal and State Laws
- Provide a 90-day advance notification to Molina of its intent to sub-delegate and include pre- delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate, and participate when applicable, in Health Plan, legal and regulatory inquiries and audits
- Comply with contractual, regulatory, and legal requirements for member and provider notification of utilization management decisions.
- Prohibit the use of verbal denials and other intangible methods of documenting physician review unless otherwise allowed by regulation or law

Claims

Claims functions may be delegated to entities that demonstrate the ability to meet regulatory and Health Plan requirements for Claims functions.

To be delegated for Claims functions, the potential delegates must at minimum:

- Pass Molina's Claims pre-assessment and annual audits, which are based on state and federal laws and regulatory and Molina established standards
- Have internal controls and quality monitoring of work performed by Claims staff
- Correct deficiencies within Molina established timeframes when issues of non-compliance are identified by Molina or a state or federal regulatory agency
- Agree to Molina's contract terms and conditions for Claims delegates
- Submit timely and complete Claims delegation reports as detailed in the Delegated Services Addendum or as communicated by Molina to the applicable Molina contact
- Comply with all regulatory standards and applicable Federal and State Laws
- Have systems enabled to accurately and timely adjudicate professional and facility claims, including but not limited to the appropriate application of interest penalties, edits, audit trail, fee schedule, provider contracting status, denial codes, payment codes, pend codes and accumulators

- Provide a 90-day advance notification to Molina of its intent to sub-delegate and include pre- delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate, and participate when applicable, in Health Plan, legal and regulatory inquiries and audits

Oversight Monitoring of Delegated Functions

Prior to approval of delegation, and at least annually thereafter, Molina conducts an onsite review of potential delegates requesting delegation. Molina uses delegation standards and practices in compliance with NCQA, State and Federal Requirements. A member or designee of the Delegation Oversight team assigned to evaluate and oversee the delegate's activities conducts the audit. Based on the audit scores and findings, if required thresholds and criteria are met, the appropriate Committee may approve specific delegation of functions. Once approved for delegation, an "Acknowledgement Acceptance of Delegation" must be signed between Molina and the Delegated Entity. For delegation of utilization management, a "Delineation of Utilization Management Responsibilities" grid is included with the Acknowledgement and Acceptance of Delegation", outlining the delegated activities; Molina's Responsibilities; the Delegated Entity's Responsibilities; the Frequency of Reporting; Molina's Process for Evaluating Performance; and, Corrective Actions if the IPA/Medical Group fails to meet its responsibilities. Adhoc audits may be conducted at the discretion of the Health Plan.

Molina reserves the right to request corrective action plans, sanction or revoke the delegation of these responsibilities when the Delegated Entity demonstrates noncompliance to NCQA, contractual, State and Federal Requirements.

Delegates must comply with all applicable State and federal laws and regulations, contract requirements, and other DHCS guidance, including Dual Plan Letters (DPLs) and applicable Policy Letters.

Complex Case Management services are not delegated to IPAs/Medical Groups. IPAs/Medical Groups are required to refer known or potential cases to Molina Case Management. The referral may be made by a telephone or facsimile. This information can also be found in the Medical Management Section and in the Public Health Coordination and Case Management.

17. MEDICARE MEMBER GRIEVANCES AND APPEALS

Distinguishing between Appeals Involving Provider Liability and Appeals Involving Member Liability

All Medicare and MMP Member liability denials are subject to the Member Appeals terms of this Provider Manual described below. The Member will receive the appropriate denial notice with appeal rights (e.g., Integrated Denial Notice, Notice of Denial of Medicare Prescription Drug Coverage, Important Message from Medicare (IM), Notice of Medicare Non-Coverage (NOMNC), or Explanation of Benefits (EOB) or Explanation of Payment (EOP) indicating there is Member responsibility assigned to a Claim processed). When Member liability is assigned, the Member Appeals process must be followed.

Disputes between Molina and a contracted Provider that do not result in an adverse determination or liability for the Member are subject to the Claims Appeals provisions of this Provider Manual. Chapter 13 of the Medicare Managed Care Manual specifically states that contracted Providers do not have appeal rights on their own behalf under the Medicare Member appeals process. Contracted Provider disputes involving plan payment denials are governed by the appeals and dispute resolution provisions of the relevant Provider Agreement. When Molina determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Agreement or Provider Manual, either administratively or by not providing the clinical information needed to substantiate the services requested, the contracted Provider is prohibited from billing the Member for the services unless Molina assigned Member liability and issued the appropriate notice with Member appeal rights. Additional information on the contracted Provider Claims appeal process can be found in the Claim Reconsideration subsection located in the Claims and Compensation section of this Provider Manual.

Definition of Key Terms used in the Medicare Member Grievances and Appeals Process

Appeal: Medicare defines an appeal as the procedures that deal with the review of adverse initial determinations made by the Plan on health care services or benefits under Part C or D that the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the Member's health) or on any amounts the Member must pay for a service or drug. These appeal procedures include a Plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

For plans providing integrated Medicare and Medicaid benefits, an Appeal includes procedures that deal with the review of adverse initial determinations made by the Plan on the health care services or benefits under the Member's Medicaid coverage under the Plan. For FIDE SNPs and certain HIDE SNPs, Appeals are called Integrated

Appeals because they incorporate Medicare and Medicaid processes. Integrated Appeals follow a Unified Appeals process. Appeals involving Medicaid-covered services or Medicare-Medicaid overlap services for an MMP may follow procedures that vary from standard Medicare rules.

Authorized Representative: An individual appointed by the Member or authorized under State law to act on behalf of the Member in filing a Grievance or Appeal. An Authorized Representative has all of the rights and responsibilities of the Member. For Medicare, a Member may be appointed using the CMS Appointment of Representative Form found at: cms.hhs.gov/cmsforms/downloads/cms1696.pdf. For Plans providing integrated Medicare and Medicaid benefits (e.g., a FIDE SNP or MMP), Medicaid rules may apply for appointing a Member representative for those services covered under Medicaid.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO or QIO): Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCC-QIOs review beneficiary complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNF), home health agencies (HHA), Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORF). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care provider (e.g., physician, hospital, etc.) and beneficiary.

Coverage Determination: Any determination made by a Part D plan sponsor, or its delegated entity, with respect to:

- A decision about whether to provide or pay for a drug that a Member believes may be covered by the Plan sponsor, including a decision related to a Part D drug that is: not on the Plan's formulary; determined not to be medically necessary; furnished by an out-of-network pharmacy; or otherwise excluded by law if applied to Medicare Part D.
- A decision on the amount of cost sharing for a drug;
- Failure to provide a Coverage Determination in a timely manner when a delay would adversely affect the Member's health;
- Whether a Member has (or has not) satisfied a prior authorization or other Utilization Management requirement;
- A decision about a tiering exception; or
- A decision about a formulary exception request.

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP): A Plan that provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both a Medicare Advantage contract with CMS and a Medicaid managed care organization contract with the applicable State; that meets certain coverage

requirements defined by Federal law; and that coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries. FIDE SNPs are subject to the Unified Grievance and Appeals procedures provided under Federal law and rules.

Grievance: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a Medicare Advantage Plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, an Appeal. Examples of a Grievance include but are not limited to the quality of care, aspects of interpersonal relationships such as rudeness of a Provider or Plan employee, waiting times for an appointment, cleanliness of contracted Provider facilities, failure of the Plan or a contracted Provider to respect the Member's rights under the Plan, involuntary disenrollment, Plan benefit design, the Organization or Coverage Determination or Appeals process, the Plan formulary, or the availability of contracted Providers.

For a FIDE SNP and certain HIDE SNPs, a Grievance is referred to as an Integrated Grievance because the Member's complaint may qualify as a Grievance under Medicare or Medicaid rules. Integrated Grievances follow a Unified Grievances process.

The Grievance process for MMPs also include dissatisfaction related to any aspect of the Plan's operations, activities, or behavior including those related to the provision of Medicaid services under the Plan.

Eligible Special Needs Plan (HIDE SNP): A dual eligible special needs plan offered by a Medicare Advantage organization that provides coverage of long-term services and supports (LTSS), behavioral health services, or both under a capitated contract between the Medicare Advantage organization and the state Medicaid agency or the Medicare Advantage organization's parent organization (or another entity that is owned and controlled by its parent organization) and the state Medicaid agency. When a HIDE SNP has exclusively aligned enrollment it is subject to the Unified Grievance and Appeals procedures provided under federal law and rules.

Medicare-Medicaid Plan (MMP): A Plan participating in a federal demonstration to provide coordinated Medicare and Medicaid benefits for dually eligible individuals. MMPs offer Medicare and Medicaid benefits as a single plan under a three-way contract by and among CMS, the state Medicaid agency, and the health plan.
Organization Determination: Any determination (an approval or denial) made by a Medicare Advantage Plan, or its delegated entity, with respect to:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services (for more information on these services see the Emergency Services, Urgent Care, and Post-Stabilization Services section of this Provider Manual);
- Payment for any other health services furnished by a provider that the Member believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare Advantage

plan;
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the Member believes should be furnished or arranged by the Medicare Advantage plan;
- Reduction or premature discontinuation of a previously ongoing course of treatment; or
- Failure of the Medicare Advantage plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the Member's health.

For a FIDE SNP and certain HIDE SNPs, an Organization Determination is called an Integrated Organization Determination because the term includes adverse benefit determinations under Medicaid. MMPs may use the term(s) Adverse Action and/or Adverse Benefit Determination in place of the term Organization Determination and may include additional circumstances within the definition such as the denial of a Member's request to obtain services outside the network when the Member resides in a rural area and there is only one MMP in the area and the denial of a Member's request to dispute a financial liability.

Medicare Member Liability Appeals

How to File an Appeal

For Standard Appeals: Members should mail or fax their written appeal to Molina at:

Molina Healthcare of California, Inc.
Attn: Grievance and Appeals
P.O. Box 22816
Long Beach, CA 90801-9977
FAX: (562) 499-0610

Expedited Appeal requests can be called in to the Molina Contact Center. Providers assisting their Members with Expedited Appeal requests should call Provider Services.

A verbal standard appeal may be accepted from **Members enrolled in Plans providing integrated Medicare and Medicaid benefits, such as a FIDE SNP or MMP.*

Members (and their authorized representatives) have 60 days from the date of the denial to file an Appeal. This timeframe may be extended for good cause.

What to Include with the Appeal

Members should include their name, contact information, Member ID number, health plan name, reason for appealing, and any evidence the Member wishes to attach. Members may send in supporting medical records, documentation or other information that explains why Molina should provide or pay for the item or service.

Participating Provider Responsibilities in the Medicare Member Appeals Process

- Providers can request expedited or standard pre-service Appeals on behalf of their Members; however, if not requested specifically by the treating physician, an Appointment of Representative Form may be required. The Appointment of Representative Form can be found online and downloaded at: cms.hhs.gov/cmsforms/downloads/cms1696.pdf.
- When submitting an Appeal, provide all medical records and/or documentation to support the Appeal at that time. Please note that if additional information must be requested, processing of the Appeal may be delayed.
- Expedited Appeals should only be requested if waiting the timeframe for a standard Appeal could jeopardize the Member's life, health, or ability to regain maximum function.

Timeframes

Appeal decisions are made as expeditiously as the Member's health condition requires and within regulatory timeframes.

Expedited Pre-Service (non-Part B, non-Part D drug)	**72 Hours
Expedited Pre-Service Part B drug	72 Hours
Expedited Pre-Service Part D drug	72 Hours
Standard Pre-Service (non-Part B, non-Part D drug)	**30 Calendar Days
Standard Pre-Service Part B drug	7 Calendar Days
Standard Pre-Service Part D drug	7 Calendar Days
Standard Post-Service (Part C)	**60 Calendar Days
Standard Post-Service Part D drug	14 Calendar Days

***Timeframes for fully integrated plans such as a FIDE SNP or MMP may vary with regulatory and contractual requirements.*

Extensions may be allowed under specific conditions (with the exception of requests involving a Part B or Part D drug).

A provider may request that a pre-service Appeal be expedited if following the standard timeframe could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. Providers must ask that an Appeal be expedited only when this standard is supported by the Member's condition.

Continuation of Benefits (aka "Aid Continuing")

Members enrolled in a Plan providing integrated Medicare and Medicaid benefits (e.g., a FIDE SNP or MMP) may be entitled to continue benefits pending appeal if authorization for services is terminated, suspended or reduced prior to the expiration of the authorization period. This typically occurs with Medicaid-covered services such as

personal care services but can be applicable to other Medicare or Medicaid services not authorized for a limited, defined benefit period when the services are terminated, suspended, or reduced prior to the expiration of the authorization period. The right to continue benefits is subject to the filing of the Appeal and/or providing a written request for continuation of benefits within 10 calendar days of the date of the notice of suspension, termination, or reduction or the expiration of the authorization, whichever is later. The right to request continuation of benefits typically resides with the member. When providers are allowed to request continuation of benefits under applicable federal and state regulations, they may be required to have the written consent of the Member to file the Appeal.

If the Member's Appeal is upheld by the Plan, their notice of the Appeal decision will contain any instructions for continuation of benefits pending State Fair Hearing.

Federal and state rules applicable to the specific Plan determine whether recovery of costs applies if the Member receives an adverse decision on Appeal or at State Fair Hearing.

Further Appeal Rights

If Molina upholds the initial adverse determination, in whole or in part, for a Part C item or service (including a Part B drug), the Appeal will be forwarded to an Independent Review Entity (IRE). (For Part D upholds, the Member must request review by the IRE.) The IRE is a CMS contractor independent of Molina. If the IRE upholds the initial adverse determination and the amount in controversy requirements are met, the Member may continue to an additional level of Appeal with an Administrative Law Judge (ALF) or attorney adjudicator. Additional levels of Appeal are available to the Member if amount in controversy requirements are met, including appeal to the Medicare Appeals Council (MAC) and federal court.

The Member may have additional appeal rights if they are enrolled in a Plan providing integrated Medicare and Medicaid benefits. In these plans, when the item or service is or could be covered by Medicaid or by both Medicare and Medicaid (overlap), the Member will be provided with their State Fair Hearing (SFH) rights and any other state appeal rights to which they are entitled. (For example, the Member may be entitled to additional appeal rights for Medicaid-covered services under the state HMO law.) Additional levels of appeal follow the applicable state rules and requirements.

Hospital Discharge Appeals

Hospital discharges are subject to an expedited Member Appeal process. Members receive their appeal rights through the delivery of the Important Message from Medicare (IM, Form CMS-10065) by the hospital. For additional information on delivery of the IM, see the Termination of Inpatient Hospital Services section of this Provider Manual.

Members disputing their discharge decision may request an immediate Appeal to the QIO for the service area (Livanta or Kepro). The Member must appeal to the QIO as soon as possible and no later than the planned discharge date and before the Member

leaves the hospital. The QIO will typically respond within one day after it receives all necessary information.

If the QIO agrees with the discharge decision, the Member will be responsible for payment for continued care beginning at noon of the calendar day follow the day the QIO provides notice of its decision to the member. The Member may request a reconsideration from the QIO if they remain in the hospital. If the QIO continues to agree with the discharge decision, the Member may appeal to an Administrative Law Judge (ALJ) or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care (aside from any applicable deductibles or copayments) without proper notification that includes their appeal rights located within the IM. The Member will then have an opportunity to appeal that subsequent discharge determination.

If the Member misses the deadline to file an Appeal with the QIO and is still in the hospital, the Member (or their authorized representative) may request an expedited pre-service Appeal with the Plan. In this case, the Member does not have financial protection during the course of the expedited pre-service Appeal and may be financially liable for paying for the cost of additional hospital days beyond the discharge date if the original decision to discharge is upheld.

SNF, CORF, and HHA Discharge Appeals

Discharges from care provided by a skilled nursing facility (SNF) (including a swing bed in a hospital providing Part A and Part B services), comprehensive outpatient rehabilitation facility (CORF), or home health agency (HHA) are subject to an expedited (fast track) Member Appeal process. For this purpose, a discharge means the complete termination of services and not the termination of a single service when other services continue (e.g., when the Member is receiving skilled nursing, skilled therapy, and home health aide services from an HHA and only the home health aide services are terminated while the other services continue). When a single service is terminated and other services continue, an Integrated Denial Notice (IDN) with Member appeal rights is issued to the member. Members receive their discharge appeal rights through the delivery of the Notice of Medicare Non-Coverage (NOMNC) by the SNF, CORF, or HHA. For additional information on delivery of the NOMNC, see the Termination of SNF, CORF, and HHA Services section of this Provider Manual.

Members disputing their discharge decision may request an expedited (fast-track) Appeal to the QIO for the service area (Livanta or Kepro). The Member must appeal to the QIO by noon of the calendar day after the NOMNC is delivered. The QIO will typically respond by the effective date provided in the NOMNC (the last covered day).

If the QIO agrees with the discharge decision, the Member will be responsible for payment for continued care received beyond the last covered day provided in the NOMNC. The Member has an opportunity to request a reconsideration from the QIO if they remain in the SNF or continue to receive services from the CORF or HHA beyond

the last covered day provided in the NOMNC. If the QIO continues to agree with the discharge decision, the Member may appeal to an Administrative Law Judge (ALJ) or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care (aside from any applicable deductibles or copayments) without proper notification that includes their appeal rights located within the NOMNC. The Member will then have an opportunity to appeal that subsequent termination of services (discharge) determination.

If the Member misses the deadline to file an Appeal with the QIO and is still in the SNF or continuing to receive services from the CORF or HHA beyond the last covered day provided in the NOMNC, the Member (or their authorized representative) may request an expedited pre-service Appeal with the Plan. In this case, the Member does not have financial protection during the course of the expedited pre-service Appeal and may be financially liable for paying for the cost of additional services provided beyond the discharge date (last covered day) if the original decision to discharge is upheld.

Obtaining Additional Information about the Member Appeal Process

For additional information about Member Appeal rights, call Molina's Provider Contact Center toll free at (855) 665-4627, or 711, for persons with hearing impairments (TTY/TDD). A detailed explanation of the Appeal process is also included in the Member's Evidence of Coverage (EOC) or Member Handbook, which is available on Molina's web site. If Members have additional questions, please refer them to Molina's Member Contact Center.

Medicare Member Grievances

A Member may file a Grievance verbally or in writing within 60 days of the event precipitating the Grievance. For Plans providing integrated Medicare and Medicaid benefits (e.g., a FIDE SNP or MMP), the Member may be allowed to file a Grievance related to their Part C or Medicaid coverage at any time.

Grievances are typically responded to by the Plan within 30 days (with some variability for certain types of Grievances for Plans providing integrated Medicare and Medicaid benefits, such as a FIDE SNP or MMP). The Plan may also be allowed to take an extension under certain circumstances.

Medicare allows an expedited grievance only if the Plan de-expedites an expedited request for an Organization Determination, Coverage Determination, or Appeal or if the Plan takes an extension in making an Organization Determination or Coverage Determination or deciding an Appeal (when allowed). These expedited Grievances are decided within 24 hours.

Members may file a Grievance by calling Molina's Member Contact Center at (855) 665-4687 or by writing to:

Molina Healthcare of California, Inc.
Attn: Grievance and Appeals
P.O. Box 22816
Long Beach, CA 90801-9977

FAX: (562) 499-0610

18. MEDICARE PART D

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

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

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

Appeals/Redeterminations

When a Member's request for a coverage determination is denied, Members may choose someone (including an attorney or Provider) to serve as their personal representative to act on their behalf. After the date of the denial, a Member has up to 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 days. If an expedited appeal is required for an emergent situation, then the decision will be made within 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 60 days of receipt of the appeal. The IRE has seven days to make a decision for a standard appeal/reconsideration and 72 hours for an expedited request. The IRE will notify Molina and the Member of the decision. When an expedited review is requested, the IRE will make a decision within 72 hours.

If the IRE changes the Molina decision, authorization for service must be made within 72 hours for standard appeals and within 24 hours for expedited appeals.

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

If the IRE upholds Molina's denial, they will inform the Member of their right to a hearing with the ALJ and will describe the procedures that must be followed to obtain an ALJ hearing.
CMS's IRE monitors Molina's compliance with determinations to decisions that fully or partially reverse an original Molina denial. The IRE is currently MAXIMUS Federal Services, Inc.

Part D Prescription Drug Exception Policy

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

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

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

Part D Exceptions and Appeals Contact Information: call toll free Molina at (855) 665-3089 or fax (866) 290-1309.

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

1. **Formulary -** A formulary is a list of medications selected by Molina in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Molina will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Molina network pharmacy, the prescription is being used for a medically accepted indication (i.e., either FDA approved or compendia supported for the diagnosis for which it is being used), and other plan rules are followed.

   Formularies may be different depending on the Molina plan and will change over time. Current formularies for all products may be downloaded from our website at: www.MolinaHealthcare.com.
2. **Copayments for Part D -** The amount a patient pays depends on which drug tier the drug is in under the plan and whether the patient fills the prescription at a preferred network pharmacy
   - Most Part D services have a co-payment;
   - Co-payments cannot be waived by Molina per CMS; and,

- Co-payments for Molina may differ by State and plan

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

4. **Non-Covered Molina Medicare Medi-Cal Program/Cal MediConnect Part D Drugs:**
   - Agents when used for anorexia, weight loss, or weight gain (no mention of medically necessary)
   - Agents when used to promote fertility
   - Agents used for cosmetic purposes or hair growth
   - 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's Medicare over the counter (OTC) monthly benefit as applicable and depending on the plan
   - Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale

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

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

6. **Requesting a Molina Medicare Formulary Exception –** Molina 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 website.

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

   A Member, a Member's appointed representative or a Member's prescribing Provider (for expedited appeals) may complete the appeal form and submit any information which may help Molina with the processing of the appeal. An appeal must be submitted in writing and filed within 60 calendar days from the date that the determination was rendered.

   - A standard appeal may be submitted to Molina in writing. The appeal will be reviewed upon receipt and the Member will be notified in writing within seven calendar days from the date the request for re- determination is received.
   - An expedited appeal can be requested by the Member or by a Provider acting on behalf of the Member in writing or can be taken over the phone. An expedited appeal may be requested in situations where applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum function. If a Provider supports the

request for an expedited appeal, Molina will honor this request.

- If a Member submits an appeal without Provider support, Molina will review the request to determine if it meets Medicare's criteria for expedited processing. If the plan determines that the request meets the expedited criteria, Molina will render a decision as expeditiously as the Member's health requires, but not exceeding 72 hours. If the request does not meet the expedited criteria, Molina will render a coverage decision within the standard redetermination time frame of seven calendar days.
- To submit a verbal request, please call toll free (855) 665-3086. Written appeals must be mailed or faxed toll free (866) 290-1309.

8. **Initiating a Part D Coverage Determination Request –** Molina will accept requests from Providers or a Member's appointed representative on the behalf of the Member either by a written or verbal request. The request may be communicated through the standardized Molina Medication Prior Authorization Request Form or through telephone via fax and telephone lines. All requests will be determined and communicated to the Member and the Member's prescribing Provider with an approval or denial decision within 72 hours/ 3 calendar days after Molina receives the completed request.

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

   a. A prescription drug is a Part D drug only if it is for a medically acceptedindication, which is supported by one or more citations included or approved for inclusion with the following compendia:
      - American Hospital Formulary Service Drug Information
      - DRUGDEX Information System
   b. Requests for off-label use of medications will need to be accompanied with excerpts from one of the two CMS-required compendia for consideration. The submitted excerpts must cite a favorable recommendation.

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

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

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

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

9. **Initiating a Part D Appeal –** If Molina's initial coverage determination is unfavorable, a Member may request a first level of appeal, or re-determination within 60 calendar days from the date of the notice of the coverage determination. In a Standard Appeal Molina has up to seven days to make the re-determination, whether favorable or adverse, and notify the Member in writing within seven calendar days from the date the request for re-determination is received. Members or a Member's prescribing Provider may request Molina to expedite a redetermination if the standard appeal timeframe of seven days may seriously jeopardize the Member's life, health, or ability to regain maximum function. Molina has up to 72 hours to make the re- determination, whether favorable or adverse, and notify the Member in writing within 72 hours after receiving the request for re- determination. If additional information is needed for

Molina to make a re- determination, Molina will request the necessary information within 24 hours of the initial request for an expedited re-determination. Molina will inform the Member and prescribing Provider of the conditions for submitting the evidence since the timeframe is limited on expedited cases.

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

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication.

Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at: www.MolinaHealthcare.com under the Health Resource tab. Please consult with your Provider Services Representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

19. RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) defines Risk Adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Molina members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

Why is Risk Adjustment Important?

Molina relies on our Provider Network to take care of our Members based on their health care needs. Risk Adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality and efficiency.
- Recognize and address current and potential health conditions early.
- Identify Members for Care Management referral.
- Ensure adequate resources for the acuity levels of Molina Members.
- Have the resources to deliver the highest quality of care to Molina Members.

Your Role as a Provider

As a Provider, your complete and accurate documentation in a Member's medical record and submitted Claims are critical to a Member's quality of care. We encourage Providers to utilize the annual visit (for all new and existing patients) to perform a comprehensive assessment of their chronic conditions and current health status. Document and code all diagnoses to the highest specificity as this will ensure Molina receives adequate resources to provide quality programs to you and our Members.

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

- Address clinical data elements (e.g. diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the Member.
- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a Provider visit with a Member. The visit may be face-to-face, or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.

RADV Audits

As part of the regulatory process, State and/or Federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Molina is appropriate and accurate. All Claims/Encounters submitted to Molina are subject to State and/or Federal and internal health plan auditing. If Molina is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Contact Information

For questions about Molina's Risk Adjustment programs, please contact your Molina Provider Services representative.

Interoperability

Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by Provider's Electronic Medical Records (EMR), including, but not limited to, Direct protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource). CCDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) CCDA standard.

Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If Provider does not have Direct Address, Provider, will work with its EMR vendor to set up a Direct Account, which also supports the Centers for Medicare & Medicare Services (CMS) requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).
- If Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.