PROVIDER MANUAL

(Provider Handbook)

Molina Healthcare of Illinois, Inc.

(Molina Healthcare or Molina)

Molina Marketplace 2026

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Molina Healthcare. “Molina Healthcare” or “Molina” have the same meaning as “Health Plan” in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaMarketplace.com.

Last Updated: 05/2026

MOLINA® HEALTHCARE

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New and Different for 2026

The following lists some of the most noteworthy additions and updates to this Molina Marketplace Provider Manual. It does **not** list all changes. Providers should review and become familiar with the entire document.

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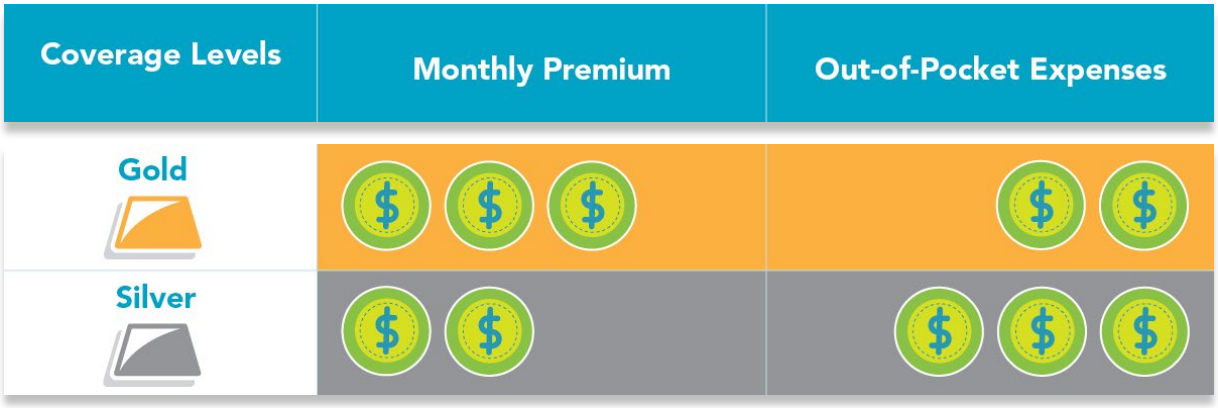
1. Introduction

Molina Marketplace plan information

Molina offers two (2) levels of affordable health plans for Members:

- Silver
- Gold



2. Contact Information

Molina Healthcare of Illinois, Inc.
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Provider Relations

The Provider Relations team addresses Provider inquiries regarding issue resolution, contracting, claims, appeals, authorizations, eligibility, Provider education and training, and general concerns. The department is staffed with Provider Relations Managers (PRM) who serve all of Molina's Provider network. Each contracted Provider is assigned a dedicated PRM who can be reached directly via their individual phone numbers and email addresses. PRMs are available Monday through Friday from 8 a.m. to 5 p.m. Central Time, excluding holidays. Providers can also use the department phone number or email address below.

Email: MHILProviderNetworkManagement@MolinaHealthcare.com
Phone: (855) 866-5462

Member Services

The Molina Member Services Contact Center handles all telephone inquiries regarding Member claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs) and Member complaints. Molina Provider Contact Center representatives (formerly Member Services Representatives) are available Monday through Friday, from 8 a.m. to 6 p.m. Central Time, excluding state and federal holidays. Eligibility verifications can be conducted at your convenience via the Availity Essentials Portal: Provider.MolinaHealthcare.com.

Phone: (833) 644-1623
Hearing Impaired (TTY/TDD): 711

Claims

Molina **strongly encourages** Participating Providers to submit claims electronically via a clearinghouse or the Availity Essentials portal whenever possible.

Availity Essentials portal: availity.com/providers
Molina's EDI Payer ID: 20934

To verify the status of your claims, please use the Availity Essentials portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity Essentials portal 24/7 year-round. For additional information, please refer to the Claims and Compensation section of this Provider Manual.

Claims recovery

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

Provider Disputes & Correspondence	Molina Healthcare of Illinois, Inc. Claims Recovery Department PO Box 2470 Spokane, WA 99210-2470
Lockbox for Refund Payments Only	Molina Healthcare of Illinois, Inc. PO Box 631264 Cincinnati, OH 45263-1264
Phone	(866) 642-8999
Fax	(855) 260-8740

Compliance and Fraud AlertLine

Suspected cases of fraud, waste, abuse, or unexplained death **must** be reported to Molina. You may do so by contacting the Molina AlertLine or by submitting an electronic complaint using the website below. For more information, please refer to the Compliance section of this Provider Manual.

Confidential
Compliance Official
Molina Healthcare of Illinois, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Online: MolinaHealthcare.Alertline.com

Credentialing

The Credentialing department verifies all information on the Provider Application prior to contracting and reverifies this information every three (3) 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. For additional information, please refer to the Credentialing and Recredentialing section of this Provider Manual.

24-Hour Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Members. Members may call any time they are experiencing symptoms or need health care information. Registered nurses are available 24/7 year-round.

Phone (English and Spanish): (833) 657-1982
Hearing Impaired (TTY/TDD): 711

Health Care Services (HCS)

The Health Care Services (HCS) department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The HCS department also performs Care Management for Members who will benefit from such 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. For additional information, please refer to the Health Care Services section of this Provider Manual.

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

- Easy-to-access 24/7 online submission and status checks.
- Ensures Health Insurance Portability and Accountability Act (HIPAA) compliance.
- Ability to receive real-time authorization status.
- Ability to upload medical records.
- Increased efficiencies through reduced telephonic interactions.
- Reduces costs associated with fax and telephonic interactions.

Molina offers the following electronic Prior Authorization/Service Request options:

- Directly to Molina via the Availity Essentials portal (preferred method).
- Via 278 transactions. See the EDI transaction section of Molina's website for guidance.

UM Fax: (833) 322-1061

Behavioral Health

Molina manages all components of our covered services for Behavioral Health. For Member Behavioral Health needs, please contact Molina directly at **(833) 644-1623**. Molina has a Behavioral Health Crisis Line that Members may access 24/7 year-round by calling the Member Services telephone number on the back of their Molina Member ID card. For additional information, please refer to the Behavioral Health section of this Provider Manual.

Pharmacy

The prescription drug benefit is administered through CVS Caremark. A list of in-network pharmacies is available at CVS Caremark - Pharmacy Locator or by contacting Molina. For additional information, please refer to the Pharmacy section of this Provider Manual.

Phone: (855) 866-5462
Hearing Impaired (TTY/TDD): 711

Quality

Molina maintains a Quality department to work with Members and Providers in administering the Molina Quality Improvement (QI) program. For additional information, please refer to the Quality section of this Provider Manual.

Phone: (855) 866-5462
Hearing Impaired (TTY/TDD): 711
Fax: (855) 556-2074
Email: quality-healthcampaigns@molinahealthcare.com

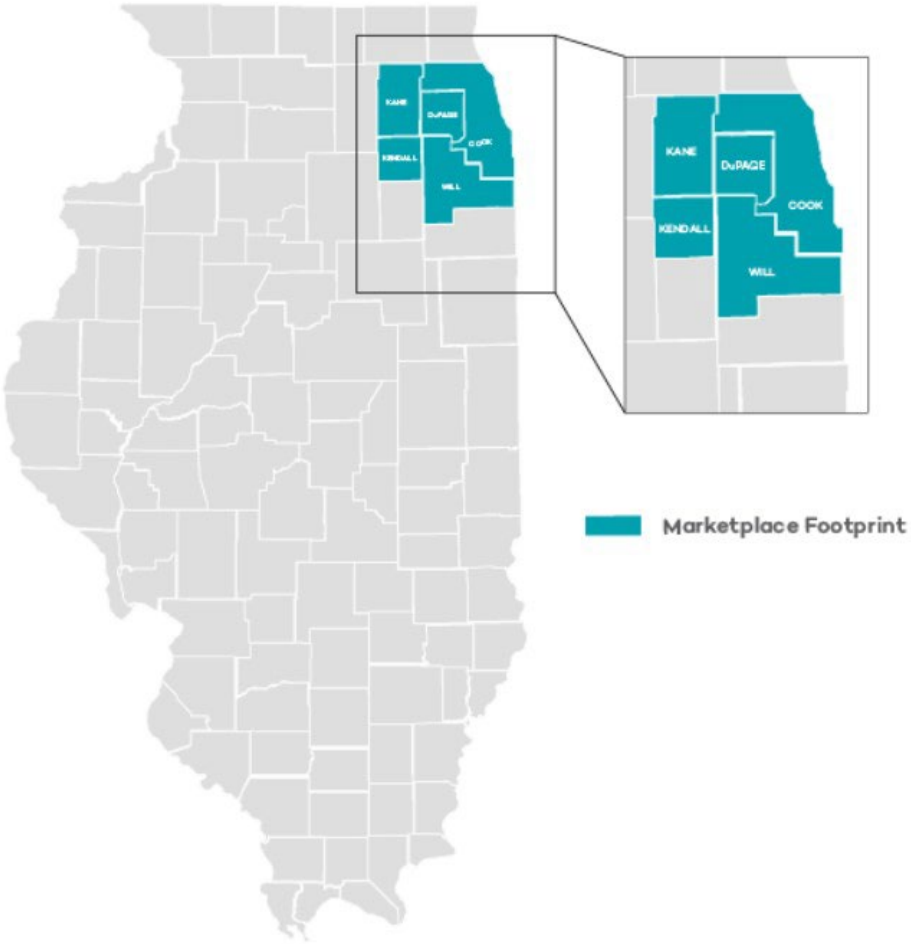
Supplemental services

Molina offers the following supplemental services benefits.

Service	Vendor Name	Contact
Dental	Delta Dental	(630) 718-4990 pr@deltadentalil.com
Vision	VSP Vision	(800) 742-6907

Molina Healthcare of Illinois, Inc. service area

Molina Healthcare currently serves Marketplace members in Cook, DuPage, Kane, Kendall, and Will counties.



3. Provider Responsibilities

Nondiscrimination in health care service delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as outlined in the Culturally and Linguistically Appropriate Services section of this Provider Manual.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to the 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 of Illinois, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
TTY/TDD: 711
Online: MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

For additional information, please refer to the Department of Health and Human Services (HHS) website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, equipment, personnel, and administrative services

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

Providers must ensure that Molina has accurate practice and business information. Accurate information allows us to better support and serve our Members and our Provider Network.

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (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 claim processing.

Please visit our Provider Online Directory at MolinaProviderDirectory.com/IL to validate your information. Providers **must** validate their Provider information on file with Molina **at least** once every 90 days for correctness and completeness.

Failure to do so may result in your REMOVAL from the Marketplace Provider directory. Provider information that must be validated includes, but is not limited to:

- Provider or practice name.
- Location(s)/address.
- Specialty(ies).
- Telephone number, fax number, and email.
- Digital contact information.
- Whether your practice is open to new patients (PCPs only).
- Tax ID and/or National Provider Identifier (NPI).

The information above must be provided as follows:

- Delegated Providers and other Providers that typically submit rosters must submit a full roster that includes the above information to Molina at MHILProviderNetworkManagement@Molinahealthcare.com.
- All other Providers must log into your Council for Affordable Quality Healthcare, Inc., (CAQH®) account to attest to the accuracy of the above information for each health care Provider and/or facility in your practice that is contracted with Molina. If the information is correct, please select the option to attest that the information is correct. If the information is not correct, Providers can make updates through the CAQH portal. Providers unable to make updates through the CAQH portal should contact their Provider Services representative for assistance.

Additionally, in accordance with the terms specified in your Provider Agreement with Molina, Providers must notify Molina of any changes as soon as possible but, at minimum, 30 calendar days in advance of any changes in any Provider information on file with Molina. Changes include but are not limited to:

- Change in office location(s)/address(es), office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition of Provider(s) (within an existing clinic/practice).
- Change in Provider or practice name, Tax ID, and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (PCPs only).
- Change in specialty.
- 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 with Molina.

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.

Molina electronic solutions requirements

Molina requires Providers to utilize electronic solutions and tools whenever possible.

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 claim submission
- Electronic Fund Transfers (EFT)
- Electronic Remittance Advice (ERA)
- Electronic claims appeal
- Registration for and use of the Availity Essentials portal

Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Availity Essentials 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 Availity Essentials portal within 30 days of entering the Molina Network.

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

Electronic solutions/tools available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic claim submission options.

- Electronic payment: EFT with ERA.
- Availity Essentials portal.

Electronic claim 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 claim submission options:

- Submit claims directly to Molina via the Availity Essentials portal.
- Submit claims to Molina through your EDI clearinghouse using **Payer ID 20934**; refer to our website at MolinaMarketplace.com for additional information.

While both options are embraced by Molina, submitting claims via the Availity Essentials portal (available to all Providers at **no cost**) offers several additional claim processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper claims. Availity Essentials portal claim submission benefits to the Provider include:

- Submitting claims through direct data entry
- Adding attachments to claims.
- Submitting claims through Quick Claims entry and saving templates
- Submitting corrected claims.
- Adding attachments to corrected claims
- Adding attachments to pending claims
- Easily and quickly voiding claims.
- Checking claim status.
- Receiving timely notification of a change in status for a particular claim.
- Saving incomplete/unsubmitted claims.
- Creating/managing claim templates.

For additional information on EDI claim submission, refer to the Claims and Compensation section of this Provider Manual.

Electronic payment 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.

Molina has partnered with ECHO Health, Inc. (ECHO) for payment delivery and EFT/835 processing. On this platform you may receive your payment via EFT/Automated Clearing House (ACH), a physical check, or a virtual card.

Note: If you have no payment preferences specified on the ECHO platform, your payments will be issued via virtual card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment (EOP) and contacting ECHO Customer Service at **(888) 834-3511** or edi@echohealthinc.com. Once your payment preference has been updated, all payments will go out in the method requested.

If you would like to opt out of receiving a virtual card prior to your first payment, you may contact Molina. If you have already received a virtual card, contact ECHO Customer Service at **(888) 834-3511** or edi@echohealthinc.com and request that your Tax ID for payer Molina Healthcare of Illinois be opted out of future virtual cards.

Once you have enrolled for electronic payments, you will receive the associated ERAs from ECHO with the **Molina Payer ID 20934**. **Note**: Providers must ensure that their Practice Management System is updated to accept Payer ID **20934**. All generated ERAs will be accessible to download from the ECHO provider portal at providerpayments.com.

ECHO has a Customer Service team available to assist Providers with any issues or questions. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Customer Service team at **(888) 834-3511**.

Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper Explanation of Payment (EOP) (i.e., Remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download, and save historical and new ERAs with a two-(2) year lookback.

Instructions about how to register are available under the EDI/ERA/EFT tab on Molina's website MolinaMarketplace.com.

Availity Essentials portal

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

- Verify Member eligibility, covered services, benefit limits, benefit accumulators and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps).

- Claims:
  - Submit Professional (CMS-1500) and Institutional (CMS-1450 aka UB-04) claims with attached files.
  - Correct/void claims.
  - Add attachments to previously submitted claims.
  - Check claim 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.
  - Submit and manage claim disputes, including formal appeals or reconsideration requests, for finalized claims
  - View, dispute, resolve claim overpayments
- Prior Authorizations/Service Requests:
  - Create and submit Prior Authorization/Service Requests.
  - Check the status of Prior Authorization/Service Requests.
  - Access Prior Authorization letters directly through the Digital Correspondence (DC) Hub functionality in the Availity Essentials portal. **Note**: Letters will only be available for Prior Authorization requests submitted via the Availity Essentials portal.
- Download forms and documents.
- Send/receive secure messages to/from Molina.
- Manage overpayment invoices (inquire, dispute, resolve)

Digital Correspondence Hub

The Digital Correspondence Hub lets your organization manage communication preferences in the Availity Essentials Portal. Only your designated Administrator can change settings, including opting out of paper letters. For updates, please contact your Administrator.

Users can also choose to receive or decline weekly reminder notifications for unopened digital letters. These reminders are not real-time alerts. Opting out of reminders does not affect your organization's digital correspondence delivery preferences.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Billing the Member

Covered services

Molina Providers are prohibited from billing the member for any covered services except for copayments, coinsurance, and deductibles.

1. Copayments, coinsurance, and any unpaid portion of a deductible may be collected from the Member at the time of service.
2. If the amount collected from the Member is higher than the actual amount owed upon claim adjudication, the Provider must reimburse the Member the overpaid amount.

Premium grace period for Members with Advanced Premium Tax Credits (APTC)

For purposes of this discussion, please note the following:

1. Premiums are billed and paid at the subscriber level; therefore, the grace period is applied at the subscriber level.
2. All Members associated with the subscriber will inherit the enrollment status of the subscriber.
3. After the initial premium is paid, a grace period of three (3) months from the premium due date is given for the payment of premium.
4. Coverage will remain in force during the grace period. If payment of premium is not received within the grace period, coverage will be terminated retroactively as of the last day of the first month during the grace period.
5. Claims for Covered Services rendered during months two (2) and three (3) of the grace period will be pended. The EX Code on the Explanation of Payment will state "LZ – Pend: Non-Payment of Premium." Claims for Covered Services rendered during month one (1) will be covered.
6. For Members who are in month two (2) or three (3) of the federal grace period and seeking services from Providers:
    a. Molina will only pay for Covered Services if the Member pays the outstanding premium payments before the grace period expires. Member's status must be verified through Molina's secure Availity Essentials portal or by calling the Molina Provider Contact Center. Providers should follow their internal policies and procedures regarding this situation.
    b. Should a Provider make the decision to render services, the Provider may collect copayment, coinsurance, or deductible from the Member. Providers must submit a claim to Molina.
    c. If the Member subsequently pays their premium and is no longer in grace period, claims will be adjudicated by Molina. The Provider must ensure appropriate Member cost-share based on the payment received from Molina.
    d. If the Member does not pay their premium and is terminated from the Molina plan, Molina will not cover any services rendered during months two (2) and three (3) of the federal grace period.

Premium grace period for Members without Advanced Premium Tax Credits (APTC)

For purposes of this discussion, please note the following:

1. Premiums are billed and paid at the subscriber level; therefore, the grace period is applied at the subscriber level.
2. All Members associated with the subscriber will inherit the enrollment status of the subscriber.

3. After the initial premium is paid, a grace period of 31 calendar days from the premium due date is given for the payment of premium.
4. Coverage will remain in force during the grace period. However, if payment of premium is not received within the grace period, coverage will be terminated retroactively as of the last day of the first month during the grace period.

Failure to obtain authorization

Providers may not bill Members for Covered Services if the Provider fails to obtain an authorization and the claim is denied by Molina.

No balance billing

Payments made by Molina to providers, less any copays, coinsurance, or deductibles (which are the financial responsibility of the Member), will be considered payment in full. Providers may not seek payment from Molina Members for the difference between the billed charges and the contracted rate paid by Molina.

Interim billing

It is the policy of Molina Marketplace not to accept interim billing for estimated monies owed to participating facilities. Claims processing will begin upon receipt of the final bill for services rendered for inpatient hospital stays and Skilled Nursing.

- Molina requires that participating Providers submit final claim upon Member's discharge from facility.
- To facilitate claims processing, it is recommended that Providers include an itemized statement and any supporting documentation with the claim submission.
- Interim billing will not be accepted. The claim will be denied until the final claim for the inpatient hospital stay or Skilled Nursing from the first date of admission through the date of final discharge is received.

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. Contact your Provider Relations Manager for information and review of proposed materials.

Member eligibility verification

Possession of a Molina Member ID card does not guarantee Member eligibility or coverage.

Providers should verify the 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:

- Availity Essentials portal
- Molina Provider Services automated phone system at (855) 866-5462

For additional information, please refer to the Eligibility and Grace Period section of this Provider Manual.

Member cost-share

Under no circumstances will Members be liable for any amount owed by Molina to the Provider. Balance billing Molina Members for services covered by Molina is prohibited. This includes asking Members to pay the difference between the discounted and negotiated fees and the Provider's usual and customary fees. In addition, Providers are responsible for verifying eligibility and obtaining approval for services that require Prior Authorization.

Providers should verify the Molina Member's cost-share status prior to requiring the Member to pay copay, coinsurance, 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 Care 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, 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 Health Care 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 can be found on the Molina website at MolinaMarketplace.com.

Additional information regarding in-network laboratory Providers and in-network laboratory Provider patient service centers can be found on the laboratory Providers' respective websites at QuestDiagnostics.com and LabCorp.com.

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with your Provider 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

Molina has a procedure to process either a referral or a standing referral request from a Primary Care Provider (PCP), Women's Principal Health Care Provider (WPHCP), or Specialist to an in-network or out-of-network specialist.

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 or outpatient behavioral health services. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers **must** document referrals in the patient's medical records and claim submission. Documentation **must** 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 that 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 from Molina will be required, except in the case of Emergency Services.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to Molina. Molina requires referring provider NPI and Taxonomy on claim submissions for specialist care. The following provider types are exempt from referring provider requirement:

- Primary Care Providers (PCP).
- Women's Principal Health Care Providers (WPHCP).
- Mental Health/Substance Use Providers.
- Emergent Care Provider.

For additional information, please refer to the Health Care Services section of this Provider Manual.

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 Providers and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate 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.

Maternal care

Molina requires that all contracted hospitals and birthing centers have policies in place that safely reduce C-sections and Early Elective Delivery (EED). Molina will enable Members to receive timely and evidence-based postpartum care. At a minimum, Molina shall provide and document the following services:

Postpartum visits, in accordance with the HFS' approved schedule, to assess and provide education on areas such as perineum care, breastfeeding/feeding practices, nutrition, exercise, immunization, sexual activity, effective family planning, pregnancy intervals, physical activity, SIDS, the importance of ongoing well-woman care, and referral to parenting classes, maternity education tools, platforms and materials, and Women, Infants, and Children (WIC).

Pharmacy program

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

Participation in Quality Improvement programs

Providers are expected to participate in Molina's Quality Improvement (QI) 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 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 (PHI).

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 Provider Disputes and Complaints, and Enrollee Appeal and Grievance Processes section of this Provider Manual.

Participation in credentialing

Providers are required to participate in Molina's credentialing and recredentialing process and will satisfy, throughout the term of their contract, all credentialing and recredentialing 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 recredentialing process.

For additional information on Molina's Credentialing program, please refer to the Credentialing and Recredentialing section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegated Services Addendum. For additional information on Molina's delegation requirements and delegation oversight, please refer to the Delegation section of this Provider Manual.

Primary Care Provider (PCP) responsibilities

PCPs are responsible for:

- Serving as the ongoing source of primary and preventive care for Members.
- Assisting with coordination of care as appropriate for the Member's health care needs.
- Recommending referrals to specialists participating with Molina.
- Appropriate triage.
- Notifying Molina of Members who may benefit from Care Management.
- Participating in the development of Care Management treatment plans.

4. Culturally and linguistically appropriate services

Background

Molina works to ensure all Members receive culturally and linguistically appropriate care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services (CLAS) in Health Care standards published by the U.S. Department of Health and Human Services (HHS) seek to improve the appropriateness and accessibility of health care services by meeting the cultural, linguistic, and accessibility related needs of individuals served.

Molina complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, and national origin, sex, age, and disability per title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities Act of 1990. Molina also complies with all implementing regulations for the foregoing. 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, sexes, 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 culturally and linguistically appropriate services is available on the Availity Essentials portal (go to Payer Spaces, Resources Tab), from your Provider Relations Manager, or by calling the Molina Provider Contact Center at **(855) 866-5462**.

Nondiscrimination in health care service delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR), state law, and federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Evidence of Coverage document on the Member website.

3. You **MUST** post in a conspicuous location in your office, a Tagline Document that explains how to access non-English language services at no cost. A sample of the Tagline Document that you will post can be found in the Evidence of Coverage document on the Member website.
4. If a Molina Member is in need of accessibility-related services, you **MUST** provide reasonable accommodations for individuals with disabilities and appropriate auxiliary aids and services.
5. If a Molina Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with Limited English Proficiency (LEP). You can find resources on meeting your LEP obligations at Limited English Proficiency (LEP) | HHS.gov and Limited English Proficiency Resources for Effective Communication | HHS.gov.
6. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 **Phone** (866) 606-3889 **TTY/TDD** 711 **Email** civil.rights@MolinaHealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **Website** ocrportal.hhs.gov/ocr/portal/lobby.jsf **Complaint Form** hhs.gov/ocr/complaints/index.html

If you or a Molina Member need additional help or more information, please call the Office of Civil Rights at **(800) 368-1019** or TTY/TDD (800) 537-7697.

Culturally and linguistically appropriate practices

Molina is committed to reducing health care disparities and improving health outcomes for all Members. Training employees, Providers and their staff and improving appropriateness and accessibility are the cornerstones of assessing, respecting and responding to a wide variety of cultural, linguistic and accessibility needs when providing health care services. Molina integrates culturally and linguistically appropriate practices training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances the way people think about service delivery, program development, and our Members so that culturally and linguistically appropriate practices become a part of everyday thinking.

Provider and community training

Molina offers educational opportunities in culturally and linguistically appropriate practices and concepts for Providers and their staff. Molina conducts Provider training during Provider

orientation, with annual reinforcement training offered through Molina Provider Relations, or with online training modules. Web-based training modules can be found on the Availity Essentials portal.

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

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

Integrated quality improvement

Molina ensures Member access to language services such as oral interpretation, American Sign Language (ASL), written materials in alternate formats, 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 MolinaMarketplace.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Key Member information, including appeal and grievance forms, is also available in threshold languages on the Molina Member website.

Access to language services

Providers may request interpreters for Members who speak a language other than English, including ASL, by calling Molina's Member Contact Center at **(833) 644-1623**. If Molina Member Contact Center representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified interpreter.

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 interpreter services to Molina Members 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.

All eligible Members who are Limited English Proficient (LEP) are entitled to receive language services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, Limited Reading Proficiency (LRP), or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility

regarding their process for obtaining such services. Molina is available to assist providers with locating these services if needed.

An individual with LEP is an individual whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English well enough to understand and communicate effectively (whether because of language, cognitive, or physical limitations). It is possible that an individual with LEP may be able to speak or understand English but still be limited to read or write in English. It is also important to not assume that an individual who speaks some English is proficient in the technical vocabulary of the health care services required.

Molina Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Be given access to Care Managers trained to work with individuals with cognitive impairments.
- Be notified by the medical Provider that interpreter services, including ASL, are available at no cost.
- Be given reasonable accommodations, appropriate auxiliary aids and services.
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
    - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records.
    - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf.
    - Interpreters must ensure that this shared information is similarly safeguarded.
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

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

When Molina Members need an interpreter, limited hearing, and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited-hearing, and/or limited-reading services are available.
- Molina is available to assist Providers with locating these services if needed:
    - Providers needing assistance finding on-site, video remote, or telephonic interpreter services.

- Providers needing assistance obtaining written materials in preferred languages.
- Providers with Members who cannot hear or have limited hearing ability may use TTY/TDD at 711.
- Providers with Members with limited vision may contact Molina for documents in large print, braille, or audio version.
- Providers with Members with Limited Reading Proficiency (LRP): The Molina Member Contact Center representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

Documentation

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

- 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

TTY/TDD connection is accessible by dialing 711. This connection provides access to the Member Contact Center, Quality, Health Care Services, and all other health plan functions.

Molina strongly recommends that Provider offices make assistive listening devices available for Members who are deaf or 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 on-site or video service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made at least three (3) business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via the Molina Member Contact Center.

24-Hour Nurse Advice Line

Molina provides a 24-Nour Nurse Advice Line for Members, which also provides access to 24-hour interpreter services. Members may call Molina's 24-Hour Nurse Advice Line directly at **(833) 657-1982** or **TTY/TDD 711** (English and Spanish). The 24-Hour Nurse Advice Line telephone numbers are also printed on Molina Member ID cards.

Program and policy review guidelines

Molina conducts assessments of the following information at regular intervals to ensure its programs most effectively meet 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 and cultural responsiveness.
- Collection of data and reporting for the Race/Ethnicity Description of Membership Healthcare Effectiveness Data and Information Set (HEDIS®) measure.
- Collection of data and reporting for the Language Description 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 across the Plan's subpopulations.
- Analysis of HEDIS® and Qualified Health Plan (QHP) Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

5. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual and on the Molina website.

The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Handbook can be found on the Member pages of Molina's website at MolinaMarketplace.com.

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 the Molina Member Contact Center at **(833) 644-1623**, Monday through Friday, 8 a.m. to 6 p.m., Central Time, excluding state and federal holidays. TTY/TDD users, please call 711.

Second opinions

If Members do not agree with their Provider's plan of care, they have the right to request a second opinion from another Provider. Members should call the Molina Member Contact Center to find out how to get a second opinion. Second opinions may require Prior Authorization.

Additional Member, Prospective Member, and Potential Member rights

A Member, Prospective Member, or Potential Member has the right to request the following from Molina:

- MCO licensure or county MCCN certification (whichever is applicable to Contractor), and the healthcare facility licensure;
- Practice guidelines maintained by Contractor in accordance with 42 CFR §438.236;
- Information about Network Providers of healthcare services, including education, board certification, and recertification, if appropriate; and
- Any Physician incentive plans in place as set forth at 42 CFR §438.3(i).

6. Eligibility and Grace Period

Eligibility verification

Health insurance marketplace programs

Payment for services rendered is based on enrollment status and coverage selected. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility listing for Molina Marketplace programs

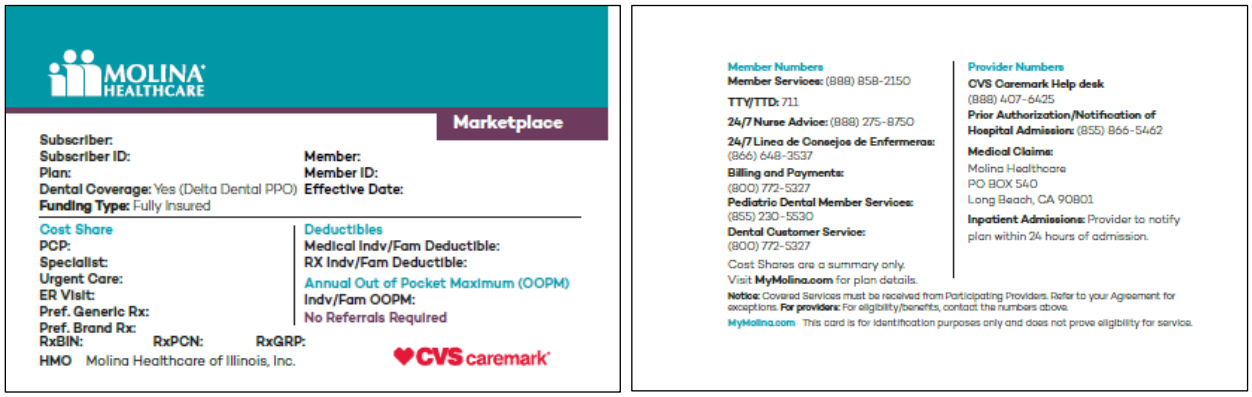
Providers who contract with Molina may verify a Member's eligibility for specific services and/or confirm PCP assignment by checking the following:

- Availity Essentials portal.
- Molina Provider Services automated Interactive Voice Response (IVR) phone system at **(855) 866-5462**.

Possession of a Marketplace Member ID card does not automatically guarantee that the holder is eligible for Marketplace services. Providers should verify eligibility each time the patient presents to their office for services. The verification sources can be used to verify a patient's enrollment in a Molina Marketplace plan.

Identification Cards

Molina Healthcare of Illinois, Inc. sample Member ID card



Members are reminded in their agreement to present ID cards when requesting medical or pharmacy services. The Molina Member ID card can be a physical ID card or a digital ID card. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment prior to rendering services. Unless an Emergency Medical Condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Grace Period

Definitions

Advanced Premium Tax Credit (APTC): Goes toward your health insurance premium—what Members pay each month to maintain health coverage.

APTC Member: A Member who receives Advanced Premium Tax Credits (premium subsidy), which helps to offset the cost of monthly premiums for the Member.

Non-APTC Member: A Member who is not receiving any Advanced Premium Tax Credits and is, therefore, solely responsible for the payment of the full monthly premium amount.

Member: An individual, including any dependents, enrolled in Molina Marketplace. This term includes APTC Members, APA Members, and Non-Subsidy APTC Members.

Summary

The Affordable Care Act mandates that all qualified health plans offering insurance through the Health Insurance Marketplace provide a grace period of three (3) consecutive months to APTC Members who fail to pay their monthly premium by the due date. Molina Marketplace also offers a grace period in accordance with state law to non-APTC Members who fail to pay their monthly premium by the due date. To qualify for a grace period, the Member must have paid at least one (1) full month's premium within the benefit year. The grace period begins on the first day of the first month for which the Member's premium has not been paid. The grace period is not a "rolling" period. Once the Member enters the grace period, they have until the end of that period to resolve the entire outstanding premium balance; partial payment will not extend the grace period.

Grace period timing

Non-APTC Members

Non-APTC Members are granted a grace period during which they may be able to access all services covered under their benefit plan. If the full past-due premium is not paid by the end of the grace period, the Non-APTC Member will be terminated using Molina's standard processes and in accordance with state and federal statutes and regulations.

APTC Members

APTC Members are granted a three (3)-month grace period. During the first month of the grace period, claims and authorizations will continue to be processed (including Pharmacy claims). Services, authorization requests, and claims may be denied or have certain restrictions during the second and third months of the grace period. If the APTC Member's full past-due premium is not paid by the end of the third month of the grace period, the APTC Member will be retroactively terminated to the last day of the first month of the grace period.

Eligibility messages

When a Member is in the grace period, Molina will include an eligibility message on the Availity Essentials portal, Interactive Voice Response (IVR), and in the call centers. This

message will provide detailed information about the Member's grace period status, including which month of the grace period the Member is in (i.e., first month vs. second or third), as well as information about how authorizations and claims will be processed during this time. Providers should verify both the eligibility status and any eligibility messages when checking a Member's eligibility. For additional information about how authorizations and claims will be processed during this time, please refer to the Member's Evidence of Coverage or contact Molina Provider Services at **(855) 866-5462**.

Notification

All Members will be notified upon entering the grace period. Additionally, when an APTC Member enters the grace period, their eligibility becomes available on the Availity Essentials portal. The online eligibility notification will inform Providers as follows:

- Members who receive APTC and have entered the first month of the grace period will not have any service restrictions. Therefore, the message that Providers will see upon checking the Availity Essentials portal will read as follows: No Enrollment Restrictions.
- Providers will be notified and are able to check that the APTC Member entered the second or third months of the grace period.
- All Providers and, specifically, Providers who have submitted claims for the APTC Member in the two (2) months prior to the start of the grace period will be notified and are able to check that the APTC Member entered the second or third months of the grace period.
- Providers will be notified and are able to check if the APTC Member is in the second or third months of the grace period before services are rendered and before submitting claims.

The online eligibility notification will advise Providers that services rendered during the second and third months of the grace period may be denied if the premium is not paid in full prior to the expiration of the third month of the grace period.

Prior Authorizations

All authorization requests will be reviewed based on Medical Necessity and will expire after 90 days. If a request for a Prior Authorization is made, the Provider will receive the following disclaimer:

> "Prior Authorization is a review of Medical Necessity and is not a guarantee of payment for services. Payment will be made in accordance with a determination of the Member's eligibility on the date of service (for Molina Marketplace Members, this includes grace period status), benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable Provider Agreement. If permitted under state law, Molina Healthcare will pend claims for services provided to Marketplace members in months 2 & 3 of the federally required grace period until such time as all outstanding premiums due are received or the grace period expires, whichever occurs first. For additional information on a Marketplace member's grace period status, please contact Molina Healthcare."

APTC Members

Authorization requests received during the first month of an APTC Member's three (3)-month grace period will be processed according to Medical Necessity standards. Authorization requests received during the second and third month of the APTC Member's grace period will be processed in accordance with state and federal statutes and regulations, and according to Medical Necessity. Authorizations issued during this time will include notification that the APTC Member is in the second or third month of the grace period, and claims for the authorized services may be denied if the premium is not paid in full by the end of the grace period.

Non-APTC Members

Authorization requests received during a non-APTC Member's grace period will be processed according to Medical Necessity standards.

Molina's adjudication of the claim will be based on the Member paying the past-due premium in full prior to the expiration of the grace period.

Claims processing

APTC Members

First Month of Grace Period: Clean claims received for services rendered during the first month of a grace period will be processed using Molina's standard processes and in accordance with state and federal statutes and regulations. And within established turnaround times.

Second/Third Month of Grace Period: Clean claims received while the APTC Member is in the grace period for services rendered during the second and third months of an APTC Member's grace period will be processed according to Molina's standard processes, within established turnaround times, and in accordance with state and federal statutes and regulations. In the event that the APTC Member is terminated for non-payment of the full premium prior to the end of the grace period, Molina will retroactively deny claims for services rendered in the second and third months of the grace period, and will issue a re-coup notice to the Provider(s) if appropriate. Pharmacy claims will be processed based on program drug utilization review and formulary edits; the APTC Member will be charged 100% of the discounted cost for prescriptions filled during the second and third months of the grace period.

Non-APTC Members

Clean claims received for services rendered during the grace period will be processed using Molina's standard processes and in accordance with state and federal statutes and regulations and within established turn-around-times.

7. Benefits and Covered Services

Molina covers the services described in the Summary of Benefits and Coverage and Schedule of Benefits documentation for each Molina Marketplace plan type. Questions regarding whether a service is covered or requires Prior Authorization can be answered using the Prior Authorization tools located on the Molina website and Availity Essentials portal. You may also contact the Molina Provider Contact Center at **(855) 866-5462,** Monday through Friday, from 8 a.m. to 5 p.m., Central Time, excluding state and federal holidays.

Verification of benefits

Detailed information about benefits and services can be found in the Schedule of Benefits made available to Molina Marketplace Members via the Molina Member Portal. Providers can access Schedule of Benefits documents via the Availity Essentials portal.

Member cost-sharing

Cost-sharing is money that Members pay out-of-pocket for Covered Services according to the plan design they have signed up for. Members may be required to meet a deductible for some Covered Services. A deductible is money a Member must pay out-of-pocket for a Covered Service before the plan starts paying for that service. Not all services have a deductible requirement.

Besides the deductible, Members will have cost-sharing for most Covered Services. Depending on the plan design, the cost-sharing will be a flat dollar amount (copayment) or percentage of the amount the provider is being paid (coinsurance) for Covered Services they are receiving. The cost-sharing amount that Members will be required to pay for each type of Covered Service is summarized on the Schedule of Benefits.

Information for some services is found on the Molina Member ID card. Cost-sharing applies to all Covered Services except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act). State or federal laws that apply to Marketplace may reduce or eliminate cost-sharing for other services.

A Member pays the lesser of the cost-sharing amount or billed charges.

It is the Provider's responsibility to collect the copayment and other Member cost-sharing from the Member to receive full reimbursement for a service. The amount of the copayment and other cost-sharing will be deducted from the Molina payment for all claims involving cost-sharing.

Formulary exception request process

A request for a formulary exception must be submitted using the same forms and procedures as submitting a prescription drug Prior Authorization request. The information submitted should show the Member's factors and medical reasons why formulary drugs are not right for

them. A copy of the Drug Formulary and Guide is found in the Provider Drug List section of MolinaMarketplace.com.

Formulary exceptions can be designated as urgent to expedite the review process and time frame:

- **Standard exception requests** are for circumstances that do not meet the definition of urgent.
- **Expedited exception requests** are for urgent circumstances that may seriously jeopardize life, health, or ability to regain maximum function, or for undergoing current treatment using the requested drug. Drug samples will not be considered as current treatment.

The Member and/or Member's representative and the prescribing Provider will be notified of Molina's decision no later than:

- 24 hours following receipt of a request for Expedited exception request.
- 72 hours following receipt of a request for Standard exception request.

If the initial request is denied, an external review may be requested. The Member and/or Member's representative and the prescribing Provider will be notified of the external review decision no later than:

- 24 hours following receipt of a request for external review of the Expedited exception request.
- 72 hours following receipt of a request for external review of the Standard exception request.

Injectable and infusion services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor designated by Molina. More information about Molina's Prior Authorization process, including a link to the Prior Authorization request form, can be found in the Pharmacy section of this Provider Manual.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered.

Access to Behavioral Health services

Behavioral Health services are a direct-access benefit and are available with no referral required. Health care professionals may assist Members in finding a Behavioral Health Provider or Members may contact Molina's Member Contact Center at **(833) 644-1623**. Molina's 24-Hour Nurse Advice Line is available 24/7 year-round for mental health or substance abuse needs. The services Members receive will be confidential.

Additional information regarding Covered Services and any limitations can be obtained in the benefit information link above or by contacting Molina. If inpatient services are needed, Prior

Authorization must be obtained, unless the admission is due to an emergency situation, and inpatient Member cost-share will apply.

Emergency mental health or substance use disorder services

Members are directed to **call the National Suicide Line at 988, call 911,** or go to the nearest Emergency Room if they need emergency mental health or substance use disorder services. Examples of emergency mental health or substance use problems are:

- Danger to self or others.
- Not being able to carry out daily activities.
- Things that will likely cause death or serious bodily harm.

Emergency services when out of the service area

Members having a health emergency who cannot get to a Molina-approved Network Provider are directed to do the following:

- Go to the nearest emergency room.
- Call the number on the Molina Member ID card.
- Call Member's PCP and follow up within 24 to 48 hours.

For out-of-area emergency care, out-of-network Providers are directed to call the Molina contact number on the back of the Molina Member ID card for additional benefit information. The Provider may be asked to transfer the Member to an in-network facility when the Member is stable.

Emergency transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air, and boat transports.

For emergency ground and air ambulance, for both in-network and out-of-network Providers, the Member is responsible only for the plan's in-network cost-sharing amount, and Providers are prohibited by state and federal law from balance billing the Member.

Preventive care

Preventive Care Guidelines are located on the Molina website at the Preventive Health Guidelines page under the Health Resources tab.

24-Hour Nurse Advice Line

Members may call the 24-Hour Nurse Advice Line any time they are experiencing symptoms or need health care information. Registered nurses are available 24/7 year-round.

Molina is committed to helping our Members:

- Prudently use the services of your office.

- Understand how to handle routine health problems at home.
- Avoid making non-emergent visits to the Emergency Room (ER).

These registered nurses **do not** diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed, unique algorithms. The 24-Hour Nurse Advice Line may refer the Member back to the PCP, to a specialist, 911, or the ER. Educating patients/Members reduces costs and overutilization of the health care system.

Telehealth and telemedicine services

Molina Members may obtain medical and behavioral health 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.
- Members have the option of receiving Telehealth services from Participating Providers that offer and have the capability of providing these services with associated plan cost-share.
- 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.
- Member cost-share may apply based on the applicable Schedule of Benefits.
- Services must be coded in accordance with applicable reimbursement policies and billing guidelines.
- Rendering Providers must comply with applicable federal and state guidelines for telehealth service delivery.

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

8. Health Care Services (HCS)

Introduction

Health Care Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. 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. Elements of the Molina Utilization Management Program include pre-service authorization review, inpatient authorization management that includes admission and concurrent review, Medical Necessity review, and restrictions on the use of out-of-network or non-participating Providers.

Utilization Management (UM)

Molina ensures the service delivered is Medically Necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care, as well as integrating a range of services appropriate to meet individual needs.

Molina's UM program maintains flexibility to adapt to changes in the Member's condition and is designed to influence a Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care.
- Evaluating the Medical Necessity and efficiency of health care services across the continuum of care.
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs.
- Coordinating, directing, and monitoring the quality and cost-effectiveness of health care resource utilization.
- Implementing comprehensive processes to monitor and control the utilization of health care resources.
- Ensuring services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure that care is safe and accessible.
- Ensuring that qualified health care professionals perform all components of the UM process.
- Ensuring that UM decision-making tools are appropriately applied in determining Medical Necessity decisions.

Key functions of the UM program

All Prior Authorizations are based on a specific standardized list of services. The key functions of the UM Program include:

- **Eligibility and oversight**
  - Eligibility verification.
  - Benefit administration and interpretation.
  - Verification that authorized care correlates to Member's medical necessity need(s) and benefit plan.
  - Verifying of current physician/hospital contract status.
- **Resource management**
  - Prior Authorization and referral management.
  - Admission, and inpatient review.
  - Referrals for discharge planning and care transitions.
  - Staff education on consistent application of UM functions.
- **Quality management**
  - Evaluate satisfaction of the UM program using Member and Provider input.
  - Utilization data analysis.
  - Monitor for possible over- or underutilization of clinical resources.
  - Quality oversight.
  - Monitor for adherence to CMS, NCQA, state, and health plan UM standards.

For more information about Molina's UM Program—or to obtain a copy of the HCS Program description, clinical criteria used for decision-making, and how to contact a UM reviewer—access the Molina website or contact the UM department.

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

UM decisions

An organizational determination is any decision made by Molina, the delegated Medical Group/IPA, or other delegated entity with respect to the following:

- Determination to authorize, provide, or pay for services (favorable determination).
- Determination to delay, modify, or deny authorizations or payment of request (adverse determination).

Molina follows a hierarchy of medical necessity decision-making, with federal and state regulations taking precedence. Molina covers all services and items required by state and federal regulations.

Board-certified, licensed reviewers from appropriate specialty areas are utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization determinations are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with federal and state regulatory requirements and NCQA standards.

Requests for authorization not meeting Medical Necessity criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a

licensed physician or pharmacist, doctoral-level clinical psychologist, or certified addiction-medicine specialist (as appropriate) may determine to delay, modify, or deny authorization of services to a Molina Member.

Providers can contact Molina's Health Care Services department at **(855) 866-5462** to obtain Molina's UM Criteria.

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

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Molina has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity Essentials portal. With MCG Cite for Guideline Transparency, Molina can share clinical indications with Providers. The tool operates as a secure extension of Molina's existing MCG resource and helps meet regulations around transparency for delivery of care:

- Transparency—Delivers medical-determination transparency.
- Access—Clinical evidence that payers use to support Member care decisions.
- Security—Ensures easy and flexible access via secure web access.

MCG Cite for Guideline Transparency does **not** affect the process for notifying Molina of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call **(888) 464-4746**.

MCG Cite AutoAuth

Molina has also partnered with MCG Health to extend the Cite AutoAuth self-service method for all lines of business to submit advanced imaging Prior Authorization (PA) requests.

Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24/7 year-round. This method of submission is **strongly encouraged** as your primary submission route. Molina will also be rolling out additional services throughout the year. Clinical information submitted with the PA will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each Prior Authorization request and sending it directly to Molina, health care Providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs, and PET scans. For a full list of imaging codes that require Prior Authorization, refer to the PA Code LookUp Tool at MolinaMarketplace.com.

Medical Necessity

Medically Necessary or **Medical Necessity** means a service that is appropriate, no more restrictive than that used in the state Medicaid Program, including quantitative or non-quantitative treatment limits, as indicated in state statutes and regulations, the state Plan, and other state policies and procedures; also the service meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with contractor's guidelines, policies, or procedures for:

- The diagnosis or treatment of a covered illness or injury.
- The prevention of future disease.
- Assisting in the Enrollee's ability to attain, maintain, or regain functional capacity.
- An Enrollee to achieve age-appropriate growth and development.

This is to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms. Molina must deem those services to be:

- In accordance with generally accepted standards of medical practice.
- Clinically appropriate and clinically significant in terms of type, frequency, extent, site, and duration.
- They are considered effective for the patient's illness, injury, or disease.
- Not primarily for the convenience of the patient, physician, or other health care Provider.
- The services must not be costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas, and any other relevant factors.

The fact that a Provider has prescribed, recommended, or approved medical or allied goods or services does not solely make such care, goods, or services Medically Necessary, a Medical Necessity, or a covered service/benefit. Prior Authorization determinations are made based on a review of Medical Necessity for the requested service.

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. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina uses nationally recognized, evidence-based

guidelines, third-party guidelines, CMS guidelines, state guidelines, Molina Clinical Policies, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Molina will not approve a Prior Authorization (PA) if information requested in connection with reviewing the PA is not provided. If a service request is not Medically Necessary, it will not be approved. If the service requested is not a Covered Service, it will not be approved. Members will get written notification informing them why the Prior Authorization request was not approved. The Member, the Member's authorized representative, or their Provider may appeal the decision. The denial decision letter will inform the Member how to appeal. If a Member or their Provider decides to proceed with a service that has not been authorized by Molina, the Member will have to pay the cost of those services.

Levels of administrative and clinical review

The Molina review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage.

The clinical review includes Medical Necessity and level of care. All UM requests that may lead to a Medical Necessity adverse determination are reviewed by a health care professional at Molina (Medical Director, Pharmacy Director, or appropriately licensed health care professional).

Molina's Provider training includes information on the UM processes and authorization requirements.

Clinical information

Molina requires that copies of clinical information be submitted for documentation. Clinical information includes but is not limited to:

- Physician emergency department notes.
- Inpatient history/physical exams.
- Discharge summaries.
- Physician progress notes.
- Physician office notes.
- Physician orders.
- Nursing notes.
- Results of laboratory or imaging studies.
- Therapy evaluations.
- Therapist notes.

Molina does not accept clinical summaries, telephone summaries, or inpatient Case Manager criteria reviews as meeting the clinical information requirements unless state or federal regulations allow such documentation to be acceptable.

Prior Authorization

Molina requires Prior Authorization (PA) for specified services, providing that the requirement complies with federal or state regulations and the Provider's Agreement with Molina. A list of services that require Prior Authorization is available in narrative form, along with a more detailed list by Current Procedural Terminology (CPT®) and Health care Common Procedural Coding System (HCPCS) codes. To see the full list of codes that require Prior Authorization, please refer to the PA LookUp Tool at MolinaMarketplace.com. Molina Prior Authorization documents are normally updated quarterly but may be updated more frequently as appropriate. They are posted on the Forms & Documents page of the Molina website.

CPT® is a registered trademark of the American Medical Association

Providers are encouraged to use the Molina Prior Authorization forms housed on the Molina website. If using a different form, the Prior Authorization request **must** include the following:

- Member demographic information (name, date of birth, Molina Member ID number).
- Provider demographic information (referring Provider and referred-to Provider/facility).
- Address and NPI number of referring Provider and referred-to Provider/facility.
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information that is sufficient to document the Medical Necessity of the requested service, including:
  - Pertinent medical history (including treatment, diagnostic tests, and examination data).
  - Requested length of stay (for inpatient requests).
  - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by federal and state law) are excluded from the Prior Authorization requirements. 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 does not retroactively authorize services that require Prior Authorization.

Molina follows all Prior Authorization requirements related to care for newborns and their mothers in alignment with the Newborns' and Mothers' Health Protection Act (NMPHA).

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the standard time frame or decision-making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences

without the care or treatment that is the subject of the request, or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

Molina will make an organizational determination as promptly as the Member's health requires, and no later than contractual and regulatory requirements. Expedited time frames are followed when the Provider indicates, or if we determine that a standard authorization decision time frame could jeopardize a Member's life or health.

Providers who request Prior Authorization for services and/or procedures may request to review the criteria used to make the final decision. A Molina Medical Director is available to discuss Medical Necessity decisions (Peer-to-Peer call) with the requesting Provider during business hours by contacting the Utilization Management department as indicated on the denial notification to schedule the call. Providers can also submit a request for "reconsideration" in place of a Peer-to-Peer call if significant information was left out of the original request.

Upon approval, the requester will receive an authorization number. The number may be provided by fax or via the Availity Essentials portal. If a request is denied, the requester and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials are also communicated to the Provider.

Peer-to-Peer review

Upon receipt of an adverse determination, the Provider (peer) may request a Peer-to-Peer discussion within five (5) business days of the notification. For inpatient admissions, a request for a Peer-to-Peer discussion may be granted within five (5) business days from discharge.

A "peer" is considered the Member's or Provider's clinical representative (licensed medical professional). Contracted external parties, administrators, or facility UM staff can only request that a Peer-to-Peer telephone communication be arranged and performed, but the discussion **must** be performed by a peer.

When requesting a Peer-to-Peer discussion, be prepared with the following information:

- Member name.
- Molina Member ID number.
- Auth ID number.
- Requesting Provider name.
- Provider contact number.
- Best times to call.

If a Medical Director is not immediately available, the call will be returned within two (2) business days. Every effort will be made to return calls as expeditiously as possible.

Note: You may always request a Reconsideration instead of a P2P.

Important: Peer-to-Peer calls are **not** recorded. Molina Medical Directors reserve the right to decline requests to record the Peer-to-Peer call. Any calls for a P2P discussion **must** be completed on a non-recorded line.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement with Molina that requires the 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 Molina's online Prior Authorization tools located on the MolinaMarketplace.com website.

- Prior Authorization Code LookUp Tool
- Prior Authorization Code Matrix
- Prior Authorization Pre-Service Review Guide

The most current Prior Authorization Guidelines and the Prior Authorization Request form can be found on the Molina website at MolinaMarketplace.com.

Availity Essentials portal

Molina is a Digital-First organization for Prior Authorization (PA) submissions, and phone- or fax-based submissions may not be available. Participating Providers should use the Availity Essentials portal for Prior Authorization submissions. All Prior Authorization submissions **must** include supporting clinical documentation to ensure timely and accurate review. Instructions for how to submit a Prior Authorization request are available on the Availity Essentials portal. The benefits of submitting your Prior Authorization request through the Availity Essentials portal include:

- 24/7 year-round service.
- Create and submit Prior Authorization requests.
- Check status of Prior Authorization requests.
- Receive notification of change in status of requests.
- Attach medical documentation required for timely medical review and decision-making.
- Receive notification of authorization decisions.
- Access Prior Authorization letters directly through the Digital Correspondence (DC) Hub in the Availity Essentials portal. **Note**: Letters will only be available for PA requests submitted via the Availity Essentials portal.

It may be necessary to submit additional documentation before the authorization can be processed.

Digital Correspondence Hub

The Digital Correspondence Hub lets your organization manage communication preferences in the Availity Essentials Portal. Only your designated Administrator can change settings, including opting out of paper letters. For updates, please contact your Administrator.

Users can also choose to receive or decline weekly reminder notifications for unopened digital letters. These reminders are not real-time alerts. Opting out of reminders does not affect your organization's digital correspondence delivery preferences.

Please refer to the Molina Prior Authorization Code List (updated quarterly) located on the Frequently Used Forms page of the MolinaHealthcare.com website under Authorization Requests.

ProgenyHealth: NICU admission and concurrent review

Molina collaborates with ProgenyHealth to provide neonatal care management services for premature and medically complex newborns in the Neonatal Intensive Care Unit (NICU).

All NICU utilization management functions, including initial admissions, continued stay requests, discharge planning, and all readmissions up to 60 days post-discharge of the initial NICU discharge, will be managed by ProgenyHealth.

Providers **must** submit NICU authorization requests and clinical documentation supporting the NICU stay directly to ProgenyHealth.

- **Phone**: (888) 832-2006, Option 2
- **UM Email**: molinamarketplaceum@progenyhealth.com
- **CM Email**: molinamarketplacecm@progenyhealth.com
- **Online**: ProgenyHealth.com

For all infants born and/or admitted to the NICU, NICU Notification of Admission must be faxed directly to ProgenyHealth at **(855) 580-6866**. The following information must be included:

- Mother's name, date of birth, Member ID number
- Infant name (if known) and Member ID number (if known)
- Attending Physician NPI number
- Facility NPI number

ProgenyHealth: Peer-to-peer review

Peer-to-peer may be requested with a ProgenyHealth Medical Director by calling **(888) 832-2006** and following the Physician Advisor's prompt and directions.

If peer-to-peer is declined or if the denial determination is upheld, providers should follow Molina's appeal process if not in agreement with the determination.

ProgenyHealth: Transfers and readmissions

ProgenyHealth will manage infants transferred from the NICU to another acute care facility under the guidance of Molina's current rules for higher, lateral, and lower-level care transfers.

ProgenyHealth will manage emergent readmissions for all infants managed by ProgenyHealth for their initial NICU admission if readmitted within the first 60 days after the **initial** NICU discharge date.

ProgenyHealth: Utilization Management cases

All concurrent stay reviews and discharge summaries should be faxed directly to ProgenyHealth.

ProgenyHealth: Care Management program review

Families will have a dedicated Case Manager who will provide support and education.

Following notification of NICU admission, ProgenyHealth outreaches caregivers for early inpatient engagement to evaluate Social Determinants of Health and barriers to safe discharge home.

ProgenyHealth Case Managers will continue to follow Molina Members for 60 days from the **initial** NICU discharge date.

ProgenyHealth Case Managers, Social Workers, and Care Coordinators assist Molina Members with identifying support and utilizing national and local community resources.

- Identifying PCP
- Behavioral health support
- Lactation services/obtaining a breast pump
- Transportation resources

ProgenyHealth will collaborate with facility CM for infants with anticipated discharge needs, complex medical care, or considerable social situations.

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 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.

Delegated Utilization Management functions

Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. They must have the ability to perform the delegated activities, and maintain specific delegation criteria in compliance with all current Molina policies, as well as regulatory and certification requirements. For additional information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Communication and availability to Members and Providers

HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff at **(855) 866-5462**, Monday through Friday (except for state and federal holidays) from 8 a.m. to 5 p.m. Central Time. All staff members identify themselves by providing their first name, job title, and organization.

TTY/TDD services are available for Members who are deaf, hard of hearing, or speech impaired. Language assistance is also always available for Members.

Providers should use the Availity Essentials portal for UM access.

Molina's Nurse Advice Line is available to Members and Providers 24/7 year-round at **(833) 657-1982 or TTY/TDD 711**. The Nurse Advice Line handles urgent and emergent after-hours UM calls.

Emergency services

Emergency services—Inpatient and outpatient health care services that are Covered Services, including transportation needed to evaluate or stabilize an emergency medical condition, and which are furnished by a Provider qualified to furnish Emergency Services.

Emergency medical condition or emergency—A medical condition manifesting itself in acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member, including the health of a pregnant woman and/or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any body part.
- Serious disfigurement.

A medical screening exam performed by licensed medical personnel in the Emergency Department and subsequent Emergency Services rendered to the Member do not require Prior Authorization from Molina.

Emergency Services are covered on a 24-hour basis without the need for Prior Authorization for all Members experiencing an emergency medical condition.

Post-stabilization care services—Covered services that are:

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

Providers requesting an inpatient admission as a post-stabilization service must request this type of service by contacting Molina's UM department at **(855) 866-5462**. Inpatient admission requests (not including post-stabilization requests) received via fax or the Availity Essentials portal will be processed within standard inpatient regulatory and contractual time frames.

Molina also provides Members with a 24-Hour Nurse Advice Line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area, Molina contracts with vendors that provide 24-hour Emergency Services for ambulances and hospitals. An out-of-network emergency hospital stay may only be covered until the Member has stabilized sufficiently to transfer to an available participating facility. Services provided after stabilization in a non-participating facility are not covered and the Member may be responsible for payment. Member payments to the non-participating facility will not apply to the Member's deductible or annual out-of-pocket maximum.

Care Managers will contact Members identified as high utilizers of emergency services and provide outreach, assessment of utilization of emergency services, and education on appropriate care and services to meet medical needs.

Molina shall not impose any requirements for Prior Approval of Emergency Services, including emergency medical screening, or restrict coverage of Emergency Services on the basis of lists of diagnoses or symptoms.

Molina shall cover Emergency Services provided to Members who are temporarily away from their residences and outside the Contracting Area to the extent that the Members would be entitled to the Emergency Services if they were still within the Contracting Area.

Molina shall cover Emergency Services regardless of whether the emergency department Provider or hospital notified the Member's PCP or Molina of the Member's services in the emergency department.

Unless a representative of Molina instructed the Member to seek Emergency Services, Molina shall have no obligation to cover medical services provided on an emergency basis that are not Covered Services.

Elective care, or care required as a result of circumstances that could reasonably have been foreseen prior to the Member's departure from the Contracting Area, is not covered. Unexpected hospitalization due to complications of pregnancy shall be covered. Routine delivery at term outside the Contracting Area, however, shall not be covered if the Member is outside the Contracting Area against medical advice, unless the Member is outside of the Contracting Area due to circumstances beyond her control. Molina must educate the Member regarding the medical and financial implications of leaving the Contracting Area and the importance of staying near the treating Provider throughout the last month of pregnancy.

Molina shall provide ongoing education to Members regarding the appropriate use of Emergency Services. Molina shall use a range of management techniques, policies, and Member or Provider initiatives to avoid unnecessary utilization of Emergency Services and to promote Care Management through a Member's PCP.

Molina shall not condition coverage for Emergency Services on the treating Provider notifying Molina of the Member's screening and treatment within ten (10) days after presentation for Emergency Services.

The determination of the attending emergency Physician, or the Provider treating the Member, of whether an Member is sufficiently Stabilized for discharge or transfer to another facility shall be binding on Molina.

Molina shall not hold a Member liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Member.

Inpatient management

Planned admissions

Molina requires Prior Authorization for all elective inpatient admissions to, and procedures in, any facility. Facilities are required to notify Molina within 24 hours or by the following business day once an admission has occurred for concurrent review. Elective inpatient admission services performed without Prior Authorization may not be eligible for payment.

Emergent inpatient admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care (including level of care), and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission, and clinical information sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting admission notification requirements, Medical Necessity requirements, or the failure to include all the required clinical documentation to support the need for an inpatient admission may result in a denial of authorization for the inpatient stay.

Inpatient at time of termination of coverage

If a Member's coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services.

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. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within 24 hours of the request.

Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an inpatient, when the clinical record supports the Medical Necessity for the need for continued hospital stay. It is the expectation that observation level of care has been tried in patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge, the Provider must provide Molina with a copy of the Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient status determinations

Molina's UM staff follow state and federal guidelines, along with evidence-based criteria, to determine if the collected clinical information for requested services is "reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of malformed body member" by meeting all coverage, coding, and Medical Necessity Review requirements. Refer to the Medical Necessity subsection earlier in this section.

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 closely with the 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 (SNF), and rehabilitative services.

Readmissions

Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines, as well as federal and state regulations.

Molina will conduct readmission reviews for all participating hospitals when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

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 30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions, and the readmission will **not** be approved for coverage.

A readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:

- Premature or inadequate discharge from the same hospital.
- Issues with transition or coordination of care from the initial admission.
- For an acute medical complication plausibly related to care that occurred during the initial admission.

Readmissions that are excluded from consideration as preventable readmissions include:

- Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
- Neonatal and obstetrical readmissions.
- Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed.
- Behavioral Health readmissions.
- Transplant-related readmissions.

Post-service review

Failure to obtain Prior Authorization when required may result in denial of payment for those services. The only possible exception for payment resulting from post-service review is if information is received indicating the Provider did not know nor reasonably could have known that the patient was a Molina Member or there was a Molina error. In those cases, a Medical Necessity Review will be performed. Decisions in this circumstance will be based on Medical Necessity and Molina's UM policies and guidance.

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

Affirmative statement about incentives

All medical decisions are coordinated and rendered by qualified Practitioners and licensed clinical staff who are unhindered by fiscal or administrative concerns. Molina and its delegated contractors **do not** use incentive arrangements to reward the restriction of medical care to Members.

Molina **requires** that all utilization-related decisions regarding Member coverage and/or services are based solely on the appropriateness of care and the existence of coverage. Molina **does not** reward practitioners or other individuals for issuing denials of coverage or care. Molina **does not** receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Out-of-network Providers and services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process to provide medical care to Molina Members. Molina requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by federal law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be Prior Authorized by Molina. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area without Prior Authorization or as otherwise required by federal or state laws or regulations.

Avoiding conflict of interest

The HCS department affirms that its decision-making is based on the appropriateness of care and service and the existence of benefit coverage.

Molina **does not** reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina never provides financial incentives to encourage authorization decision-makers to make determinations that result in underutilization. Molina also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

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.

Molina staff provide an integrated approach to care needs by assisting Members with the identification of resources available to the Member, such as community programs, national support groups, appropriate specialists and facilities, dental and vision services, and identifying best practices 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 their efforts are efficient and non-duplicative.

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 and provide continued services to Members undergoing a course of treatment by a Provider that has terminated its 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 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 email Molina at CMEscalationIL@MolinaHealthcare.com or call **(855) 866-5462**.

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, neglect, exploitation, unexplained death

A vulnerable adult is a person who is receiving or may need community-care services by reason of mental or other disability, age or illness, or who is or may be unable to take care of, or unable to protect themself 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 child care givers.
- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers.

If you believe anyone is in immediate danger, call 911 first. All critical incidents and cases of suspected abuse and/or neglect should be reported to the Molina Quality team:

Phone: (855) 866-5462
Fax: (855) 556-2074
Email: MHIL-QI@molinahealthcare.com

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

Child abuse

For abuse, neglect, or exploitation of Members under the age of 18, call the Illinois Child Abuse Hotline (Department of Children and Family Services) 24/7 at **(800) 25ABUSE—(800) 252-2873**—or TTY **(800) 358-5117**. Doing so complies with the Abused and Neglected Child Reporting Act 325 ILCS 5/1 et seq. Call if you suspect that a child has been harmed or is at risk of being harmed by abuse or neglect. If you believe a child is in immediate danger, **call 911 first.**

Adult abuse

For Members who are aged 18 and older and living in the community, reports go to the Illinois Department on Aging via the Adult Protective Services Hotline number at **(866) 800-1409** or TTY/TDD **(800) 206-1327**. This complies with the Adult Protective Services Act 320 ILCS 20/1-1 et seq., the Abuse of Adults with Disabilities Intervention Act 20 ILCS 2435/1 et seq., and the Elder Abuse and Neglect Act 320 ILCS 20/1 et seq.

For Members residing in Supportive Living Facilities (SLF), reports go to the Department of Health care and Family Services' SLF Complaint Hotline at **(800) 226-0768**. This complies with the 89 Ill. Adm. Code, Section 146.305 for Reporting of Suspected Abuse, Neglect, and Financial Exploitation in Specialized Health Care Delivery Systems through the Department of Health care and Family Services Medical Programs.

For Members aged 18 to 59 receiving mental health or Developmental Disability services in DHS operated, licensed, certified, or funded programs, use the Illinois Department of Human Services Office of the Inspector General Hotline at **(800) 368- 1463** (voice and TTY). Doing so complies with the Department of Human Services Act 20 ILCS 1305/1-1 et seq.

For Members who are residing in Nursing Facilities, reports go to the Department of Public Health's Nursing Home Complaint Hotline at **(800) 252-4343**. This complies with the Abused and Neglected Long Term Care Facility Residents Reporting Act 210 ILCS 30/1 et seq.

To report suspected abuse, neglect, or financial exploitation of an adult age 60 or older or a person with disabilities age 18 to 59, call the statewide, 24-hour Adult Protective Services Hotline at **(866) 800-1409** or TTY/TDD (888) 206-1327.

Molina's HCS team will work with PCPs, Medical Groups/IPAs, 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 who 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 Health Care Services Committee and the proper state agency.

PCP responsibilities in care management referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The Care Manager provides the PCP with the Member's Individualized Care Program (ICP), Interdisciplinary Care Team (ICT) updates, and information regarding the Member's progress through the ICP when requested by the PCP. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Care Manager responsibilities

The Care Manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions from the Member's ICT, as applicable. ICP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the Care Manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the Care Manager:

- Completes assessment with the Member to determine if the Member's needs would benefit from Case Management.
- Monitors and communicates the progress of the implemented ICP to the Member's ICT, as the Member's needs warrant.
- Serves as a coordinator and resource to the Member, their representative(s), and ICT participants throughout the implementation of the ICP, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management, including the development of a health action plan to manage symptoms and changes in condition with their Provider.
- Monitors progress toward the Member's achievement of ICP goals to determine an appropriate time for the Member's graduation from the ICM Program.

Health management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members. Level 1 Members

can be engaged in the program for up to 90 days, depending on Member preferences and the clinical judgement of the Health Management team.

Level 1 health management

Molina offers programs to help our Members and their families manage a diagnosed health condition. The Molina My Health programs include telephonic outreach from our clinical staff and health educators that includes condition-specific triage assessment, care plan development, and access to tailored educational materials. Members are identified via Health Risk Assessment (HRA), and identification and stratification.

Providers can also directly refer Members who may benefit from these program offerings by contacting Molina. Members can request to be enrolled or disenrolled in these programs at any time. The chronic conditions programs include:

- Asthma
- Depression
- Diabetes
- COPD
- Heart Failure
- Hypertension

Molina healthy lifestyle programs include:

- Weight Management
- Tobacco Cessation
- Nutrition consult

Main phone: (833) 269-7830
Healthy lifestyle programs: (866) 472-9483
TTY/TDD: 711
Fax: (800) 642-3691

Maternity screening and high-risk obstetrics

Molina offers all pregnant Members prenatal health education with resource information as appropriate, and screening services to identify high-risk pregnancy conditions. Care Managers with specialized obstetrics (OB) training provide additional care coordination and health education for Members with identified high-risk pregnancies to assure best outcomes for Members and their newborns during pregnancy, delivery, and through their sixth (6th) week post-delivery. Pregnant Member outreach, screening, education, and Care Management are initiated by Provider notification to Molina, Member self-referral, and internal Molina notification processes. Providers can notify Molina of pregnant/high-risk pregnant Members via faxed Pregnancy Notification Report Forms.

Pregnancy notification process

The PCP shall submit to Molina the Pregnancy Notification form (available on the website) within one (1) working day of the first prenatal visit and/or positive pregnancy test.

The information may be phoned, faxed, or emailed to Molina:

Phone: (855) 866-5462
Fax: (844) 479-5341
Email: Quality-HealthCampaigns@MolinaHealthcare.com

Member newsletters

Member Newsletters are posted on the MolinaMarketplace.com website at least once per year. The articles are about topics requested by Members. The tips are intended to help Members stay healthy.

Member health education materials

Members can access our easy-to-read, evidence-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression, and other relevant health topics identified during our engagement with Members. Materials are available through the Member Portal, direct mail as requested, email, and the My Molina app.

Program eligibility criteria and referral source

Health Management (HM) Programs are designed for Molina Members with a confirmed diagnosis. Identified Members will receive targeted outreach, such as educational materials, telephonic outreach, or other materials to access information on their condition. Members can contact the Molina Member Contact Center at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include:

- Pharmacy claims data for all classifications of medications.
- Encounter Data or paid claims with a relevant CMS-accepted diagnosis or procedure code.
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- Member assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members.
- External referrals from Providers, caregivers, or community-based organizations.
- Internal referrals from the Nurse Advice Line, Medication Management, or Utilization Management.
- Member self-referral due to general plan promotion of the program through the Member newsletter or other Member communications.

Provider participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease.
- Clinical resources, such as patient assessment forms and diagnostic tools.
- Patient education resources.
- Provider Newsletters promoting the Health Management Programs, including outcomes of the programs and how to enroll patients.
- Clinical practice guidelines.
- Preventive health guidelines.
- Case Management collaboration with the Member's Provider.
- Faxing a Provider Collaboration form to the Member's Provider when indicated.

Additional information on Health Management Programs is available from Molina's Health Care Services department at **(866) 891-2320**.

Primary Care Providers (PCP)

Molina provides a panel of Primary Care Providers (PCP) 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. Members are required to see a PCP who is part of the Molina Network. Members may select or change their PCP by calling the Molina Member Contact Center at **(833) 644-1623** or TTY/TDD 711.

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no Prior Authorization is required.

Members are allowed to directly access women's health specialists for routine and preventive health without Prior Authorization or referral.

Molina will help to arrange specialty care outside the Network when Providers are unavailable or the Network is inadequate to meet a Member's medical needs. To obtain such assistance, contact the Molina UM department. Referrals to specialty care outside the Network require Prior Authorization from Molina.

Care Management (CM)

Molina provides a comprehensive ICM Program to all Members who meet the criteria for services. The ICM Program focuses on coordinating the care, services, and resources needed by Members throughout the continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina Care Managers may be licensed professionals and are educated, trained, and experienced in Molina's ICM Program. The ICM Program is based on a Member-advocacy philosophy, designed and administered to assure the Member value-added coordination of

health care and services to increase continuity and efficiency, and to produce optimal outcomes. The ICM Program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP.

The Molina Care Manager will complete an assessment with the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Care Manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of the ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

Referral to Care Management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP, specialty care Provider, themselves, caregiver, discharge planner, or Molina Health Care Services to the ICM Program. The Care Manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP and specialty Providers, ancillary Providers, the local health department, or other community-based resources when identified. The referral source should be prepared to provide the Care Manager with demographic, health care, and social data about the Member being referred.

Members with the following conditions may qualify for Care Management and should be referred to the Molina ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery.
- Catastrophic or end-stage medical conditions (e.g., neoplasm, organ/tissue transplants, End Stage Renal Disease).
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF, etc.).
- Members receiving seven (7) or more medications.
- Preterm infants.
- High-tech home care requiring more than two (2) weeks of treatment.
- Member accessing Emergency Department services inappropriately.
- Children with special health care needs.

Referrals to the ICM Program may be made by emailing Molina at:

Phone: (855) 866-5462
Email: CMEscalationIL@MolinaHealthcare.com

9. Behavioral Health

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. Molina complies with the current Mental Health Parity and Addiction Equity Act requirements. All provisions within the Provider Manual are applicable to medical and Behavioral Health Providers.

Utilization Management and Prior Authorization

For additional information, please see the Prior Authorization subsection in the Health Care Services section of this Provider Manual.

Some behavioral health services may require Prior Authorization (PA).

Behavioral Health inpatient, substance use disorder residential services, psychiatric residential treatment, and select outpatient treatment(s) can be requested by submitting a PA request form or contacting Molina's Prior Authorization team at **(855) 866-5462**, Monday through Friday from 8 a.m. to 5 p.m. Central Time (excluding state and federal holidays). Molina **strongly recommends** using the Availity Essentials portal to submit all Prior Authorization requests.

Emergency psychiatric services do not require Prior Authorization; they do, however, require notification to Molina.

All requests for Behavioral Health services should include a mental health diagnosis using the most current versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) as well as current clinical information supporting the request. Molina utilizes standard, generally accepted Medical Necessity criteria for Prior Authorization reviews.

Access to Behavioral Health Providers and PCPs

Members may be referred to an in-network Behavioral Health Provider via referral from a Primary Care Primary Care Provider (PCP), medical specialist, or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of any known or suspected Behavioral Health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health service within the scope of their practice and in compliance with all state and regulatory requirements for the service provision. A formal referral form or Prior Authorization is not needed for a Member to self-refer or be referred to a PCP, specialist, or Behavioral Health Provider. However, individual services provided by non-network Behavioral Health Providers will require Prior Authorization.

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

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, to occur within seven (7) days of the discharge date.

Interdisciplinary care coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration among all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care between each other for the benefit of the Member. Collaboration of the treatment team will increase the 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 among all Providers of a Member's treatment team. Additional information on the Care Management program can be found in the Care Management subsection found in the Health Care Services section of this Provider Manual.

Care Management

Molina's Care Management (CM) team includes licensed nurses and clinicians with Behavioral Health experience to support Members with mental health and/or Substance Use Disorder (SUD) needs. Members with high-risk psychiatric, medical, or psychosocial needs may be referred by a Behavioral Health professional or Primary Care Provider to the care management program.

Referrals to the care management program may be made by:

Phone: (855) 866-5462
Email: CMEscalationIL@MolinaHealthcare.com

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

Behavioral Health Care Management

Access to Records and Information to Support Member Care Coordination and Care Management Activities

Molina is committed to working with its Providers to address the care coordination and care management needs of its members. To facilitate such activities, all Providers (including

Substance Use Disorder providers and Behavioral Health providers) are required to cooperate with and provide to Molina any and all relevant patient/member records and information requested by Molina to support such activities. To the extent a consent and/or authorization from the patient/member is required by law to disclose the requested records/information to Molina, the Provider shall make best efforts to obtain the necessary consent(s) and/or authorization(s) from the patient/member.

Both Molina and the Provider agree to comply with HIPAA and other applicable federal and state privacy laws and regulations including, but not limited to, the HIPAA privacy regulations set forth in 45 C.F.R. Part 164 Subpart E, the HIPAA security regulations set forth in 45 C.F.R. Part 164 Subpart C, 42 C.F.R. Part 2 Regulations governing the Confidentiality of Substance Use Disorder Patient Records and state-specific medical privacy laws.

Responsibilities of Behavioral Health Providers

Molina promotes collaboration between Providers and integration of both physical and Behavioral Health services in an effort to provide quality care coordination to Members. Behavioral Health Providers are expected to provide in-scope, evidence-based mental health and SUD 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 that Members can obtain needed health services within the acceptable appointment time frames. Please refer to the Quality section of this Provider Manual for specific access to appointment details.

Molina requires patients in inpatient hospital settings to be seen by an appropriate physician (MD/DO) or advanced practice nurse every day. Face-to-face visits are preferred; however, telehealth visits may be used under certain circumstances. Refer to the Telehealth section.

- For Behavioral Health/mental health care, the provider seeing the member daily **must** be a psychiatrist (MD/DO) or a certified mental health nurse practitioner.
- Any inpatient stay that does not have a face-to-face evaluation by an appropriate physician or advanced practice nurse will result in denial of the day the member did not receive this level of care.

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 (7) 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 24-Hour Nurse Advice Line as listed on the back of the Molina Member ID card:

Phone: (833) 657-1982
TTY/TDD: 711

National Suicide Lifeline

The National Suicide Lifeline is reached by **dialing 988**. Anyone in need of suicide or mental health crisis support or anyone with concerns about someone else can receive free and confidential support 24/7 year-round by **dialing 988** from any phone.

Behavioral Health Toolkit for Providers

Molina has developed an online Behavioral Health Toolkit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to Behavioral Health Healthcare Effectiveness Data and Information Set (HEDIS®) Tip Sheets, and other evidence-based guidance, training opportunities for Providers, and recommendations for coordinating care. The material within this toolkit is applicable to Providers in both medical and Behavioral Health settings. The Behavioral Health Toolkit for Providers can be found under the "Health Resources" tab on the MolinaMarketplace.com Provider website. HEDIS® Tip Sheets are located in the Availity Essentials portal.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

10. 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 at **(855) 866-5462**.

The address for mail requests:

Molina Healthcare of Illinois, Inc.
Quality Department
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

This Provider Manual contains excerpts from the Molina Quality Improvement (QI) Program. For a complete copy of Molina's QI Program, contact your Provider Relations Manager or call the telephone number above to receive a written copy.

Molina has established a QI Program that complies with regulatory requirements and accreditation standards. The QI 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 Physician Associations (IPA). However, Molina requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care. Molina Medical Groups/IPAs must:

- Have a quality improvement program in place.
- Comply with and participate in Molina's QI Program, including reporting of Access and Availability survey and activity results and provision of medical records as part of the Healthcare Effectiveness Data and Information Set (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, as well as the 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.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Patient safety program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe health practices for our Members through our Safety Program, Pharmaceutical Management, and

Care Management/Health Management Programs and education. Molina monitors nationally recognized quality index ratings for facilities, including adverse events and hospital-acquired conditions, as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA) and the Department of Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

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 is 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 be 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 medical record. PCPs should maintain the following medical record components, which 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

This list describes the minimum items that are necessary in the maintenance of the Member Medical records:

- Each patient has a separate medical record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available during 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 the thickness of the record dictates.
- If electronic, all those with access have individual passwords.

- Record-keeping is monitored for quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language, and sexual orientation and gender identity.
- Storage maintenance for the determined timeline and disposal per record management processes.
- Process is in place 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, but not be limited to, the following information:

- The patient's name and/or ID number on each page in the record.
- The patient's name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of the Provider and other staff members in a paper chart.
- A list of all Providers who participate in the Member's care.
- Information about services delivered by these Providers.
- Weight and height information and, as appropriate, growth charts.
- 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 with evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that shows Advance 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, with the specific time of return noted in weeks, months, or as needed, included in the next preventative care visit when appropriate.
- Notes from consultants as applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow-up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions and follow-up care, inpatient and outpatient care, including hospital discharge summaries, hospital history and physicals, and operative report.
- Labor and delivery record for any child seen since birth.
- Family planning and counseling, obstetrical history, and profile.
- 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 the facilitation of medical care.

Retrieval

- The medical record is available to the 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 and/or federal agency and the external quality review organization upon request.
- The medical record is available to the Member upon request.
- A storage system for inactive Member medical records that 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 (1) 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

Providers shall develop and implement confidentiality procedures to guard Member Protected Health Information (PHI) in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include, and is not limited to:

- Ensure that medical information is released only in accordance with applicable federal or state law in 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.
- Protect medical records from unauthorized access.
- Restrict access to computerized confidential information.
- Take precautions to prevent inadvertent or unnecessary disclosure of protected health information.
- Educate and train all staff on handling and maintaining PHI.
- Ensure the confidentiality of information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity, and Health-Related Social Needs (HRSN).

Additional information on medical records is available from the Molina Quality department at **(855) 866-5462**. For additional information regarding HIPAA, please see the **Compliance** section of this Provider Manual.

Advance Directives (Patient Self-Determination Act)

Molina complies with the Advance Directives requirements of the states in which the organization provides services. Responsibilities include ensuring Members receive information regarding Advance Directives, and that contracted Providers and facilities uphold executed documents.

Advance Directives are a written choice for health care. Illinois has four (4) types of Advance Directives:

- **Health care power of attorney**—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.
- **Do-Not-Resuscitate order (DNR)**—A medical order stating that cardiopulmonary resuscitation cannot be performed if the heart or breathing stops.
- **Mental health treatment preference declaration**—Allows the Member to state whether they want to receive electroconvulsive treatment or psychotropic medicine.

The absence of Advance Directives

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 of age 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 the Molina Member Contact Center or are directed to the CaringInfo website at caringinfo.org for downloadable

forms. 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 regulations give 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 Directive instructions.

Molina will notify the Provider of an individual Member's Advance Directive 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. Advance Directive forms are state-specific to meet state regulations.

Molina expects that there will be documented evidence of the discussion between the Provider and the Member during routine Medical Record reviews.

Access to care

Molina maintains access-to-care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed regarding their appointment availability include PCPs (family/general practice, internal medicine, and pediatric), OB/GYN (high-volume specialists), oncologists (high-impact specialists), and Behavioral Health Providers.

Providers are required to conform to the access-to-care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or designee must be available 24/7 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 time frames noted:

Medical appointment access

Medical Appointment Types	Standard
Routine preventive care	Within 15 business days
Routine preventive care for infants under 6 months of age	Within 2 weeks

Medical Appointment Types	Standard
Routine, symptomatic, but not deemed serious	Within 7 calendar days
Urgent care	Within 24 hours
After-hours/emergency care	24/7 year-round
Specialty care (high-volume)	Within 30 business days
Specialty care (high-impact)	Within 30 business days
Urgent specialty care	Within 24 hours
Initial prenatal visit—first trimester	Within 2 weeks
Initial prenatal visit—second trimester	Within 1 week
Initial prenatal visit—third trimester	Within 3 days

Behavioral Health appointment access

Behavioral Health 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
Follow-up routine care visit	Within 10 business days

Additional information on appointment access standards is available from the Molina Quality department at **(855) 866-5462**.

Office wait time

For scheduled appointments, the wait time in offices should not exceed 60 minutes from appointment time. All PCPs are required to monitor waiting times and adhere to this standard.

After hours

All Providers must have backup (on-call) coverage after hours, or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, seven (7) days per week. The Provider must have a published after-hours telephone number. This access may be through an answering service or a recorded message, which should instruct Members with an Emergency to hang up and **call 911** or go immediately to the nearest Emergency Room. Voice mail alone is **not** acceptable for after-hours coverage.

Women's health access

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

Additional information on access to care is available from the Molina Quality department at **(855) 866-5462**.

Monitoring access for compliance with standards

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

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

- **Provider access studies**—Provider office assessment of appointment availability, after-hours access, Provider ratios, and geographic access.
- **Member complaint data**—Assessment of Member complaints related to access and availability of care.
- **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 and Health Equity Transformation 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 and Health Equity Transformation Committee.

Quality of Provider office sites

Molina Providers are to maintain office-site and medical record-keeping practices standards. Molina continually monitors Member appeals and complaints/grievances for all office sites to determine the need for 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. 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, 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 overall compliance with the following guidelines:

- 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 the 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 (2) 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 (1) CPR-certified employee is available.
- Yearly Occupational Safety and Health Administration (OSHA) training (fire, safety, bloodborne pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- A hazardous waste management system in place, with labeled containers, policies, and contracts.
- 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 Clinical Laboratory Improvement Amendments (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.
- A system is 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.

Services to Enrollees under 21 years of age

Molina maintains systematic and robust monitoring mechanisms to ensure all preventive services necessary for Members under 21 years of age are timely according to required

preventive health guidelines. All Members under 21 years of age should receive screening examinations, including appropriate childhood immunizations, at intervals specified by the Preventive Health Guidelines found on the Molina Provider website and referenced in the Benefits and Covered Services section of this Provider Manual.

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, 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 screening for preventive services. Only Medically Necessary services are covered. Pediatric routine vision services (one eye exam per year) is accessed by Members through the VSP network.
- Hearing screening for preventive services.
- Dental assessment and services.
- Health education, including anticipatory guidance, such as child development, healthy lifestyles, and 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 that the Provider submits a written CAP 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 Provider's 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.

Quality Improvement activities and programs

Molina maintains an active Quality Improvement (QI) Program. The QI Program provides structure and key processes to carry out our ongoing commitment to the improvement of care and service. Molina focuses on reducing health care disparities through the QI Program. 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 refer to the Health Care Services section of this Provider Manual.

Clinical Practice Guidelines (CPG)

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 appropriately established authority.

Molina CPGs include the following:

- Acute stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/panic disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar disorder
- Children with Special Health Care Needs
- Chronic kidney disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Community reintegration and support
- Coronary artery disease (CAD)
- Dental services
- Depression
- Diabetes
- Heart failure in adults

- Homelessness/special health care needs
- Hypertension
- Long-Term Care (LTC) residential coordination of services
- Mental health
- Obesity
- Opioid management
- Perinatal Care
- Pharmacy services.
- Pregnancy management
- Prenatal, obstetrical, postpartum, and reproductive health care
- Psychotropic medication management
- Schizophrenia
- Sickle cell disease
- Smoking cessation
- Substance Abuse Treatment
- Suicide Risk
- Trauma-informed primary care

All CPGs are updated at least annually—and more frequently, as needed when clinical evidence changes—and are approved by the Quality Improvement and Health Equity Transformation Committee. In fact, a review is conducted at least monthly to identify new additions or modifications. On an annual basis or when changes are made during the year, CPGs are distributed to Providers at MolinaMarketplace.com and in the Provider Manual. Notification of the availability of the CPGs is published in the Molina Provider Newsletter.

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 the Centers for Disease Control and Prevention (CDC), in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Adult preventive services recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on Molina's website.
- Recommendations for preventive pediatric care (Bright Futures/American Academy of Pediatrics). Links to current recommendations are included on Molina's website.
- Recommended adult immunization schedule for ages 19 years or older (United States). These recommendations are revised every year by the Centers for Disease Control and Prevention (CDC). Links to current recommendations are included on Molina's website.
- Recommended child and adolescent immunization schedule for ages 18 years or younger (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on Molina's website.

All preventive health guidelines are updated at least annually—and more frequently as needed when clinical evidence changes—and are approved by the Quality Improvement and Health Equity Transformation Committee. On an annual basis or when changes are made during the year, Preventive Health Guidelines are distributed to Providers at MolinaMarketplace.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Culturally and linguistically appropriate services

Molina works to ensure that 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 refer to the Culturally and Linguistically Appropriate 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®).
- Qualified Health Plan (QHP) Enrollee experience survey
- Behavioral Health satisfaction assessment
- 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 local/health plan level.

Contracted Providers and facilities must allow Molina to use 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:

- Development of quality improvement activities.
- Public reporting to consumers.
- Preferred status designation in the Network.
- Reduced Member cost-sharing.

Molina's most recent results can be obtained from Molina Quality department staff at **(855) 866-5462** or fax to **(855) 556-2074** or by visiting our website at MolinaMarketplace.com.

HEDIS®

Molina utilizes NCQA Healthcare Effectiveness Data and Information Set (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-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations. The data are also used to compare against established health plan performance benchmarks.

HEDIS® is a registered trademarks of the National Committee for Quality Assurance (NCQA).

Qualified Health Plan (QHP) Enrollee experience survey

The QHP Enrollee experience survey is a consumer experience survey that assesses Enrollee (Member) experience with QHPs offered through Marketplaces. This survey is fielded nationally by Department of Health & Human Services (HHS)-approved survey vendors using a standardized protocol to facilitate QHP comparison both within and across Marketplaces.

The QHP Enrollee experience survey was designed to collect accurate and reliable information from consumers about their experience with the health care they received through QHPs in the Health Insurance Marketplace. The survey includes a set of core questions that address key areas of care and service, with some questions grouped to form composites.

QHP Enrollee experience survey topics include:

- Access to care
- Access to information
- Care coordination
- Cost
- Cultural competence
- Doctor's communication
- Plan administration
- Prevention

Behavioral Health satisfaction assessment

Molina obtains feedback from Members about their experience, needs, and perceptions regarding 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, and receiving treatment and information from the plan, among other areas.

Provider satisfaction survey

Recognizing that HEDIS® and QHP 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 data on requests for out-of-network services to determine opportunities for service improvements.

Quality rating system for Marketplace

Based on Section 1311(c)(3) of the Affordable Care Act, CMS developed the Quality Rating System (QRS) to:

- Provide comparable and useful information to consumers about the quality of health care services provided by QHPs.
- Facilitate oversight of QHP-issuer compliance with Marketplace quality standards.
- Provide actionable information for improving quality and performance.

Quality ratings are calculated for each eligible QHP product using clinical quality and Enrollee experience survey data. Based on results, CMS will calculate and produce quality performance ratings for each health plan on a one-to-five-star rating scale.

Measures are organized into a hierarchical structure designed to make the QRS scores and ratings more understandable. They include but are not limited to:

- Clinical effectiveness
- Patient safety
- Prevention
- Access and coordination
- Doctor and care
- Efficiency and affordability
- Plan service

What can Providers do?

- Ensure that 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 the patient's age and/or condition has been missed.
- Check that staff are properly coding all services provided.
- Be sure that 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 Availity Essentials portal. In it are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and QHP Enrollee Experience Survey Star Ratings measures, contact the Molina Quality department.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

11. Risk Adjustment Accuracy and Completeness

What is risk adjustment?

CMS defines risk adjustment as a process that helps to 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 chronic conditions.

Interoperability

The 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 the Provider's Electronic Medical Records (EMR), including but not limited to Epic Payer Platform, Direct Protocol, Secure File Transfer Protocol (sFTP), query, or web service interfaces such as Simple Object Access Protocol (SOAP External Data Representation) or Representational State Transfer (REST Fast Healthcare Interoperability Resource). The CDA or CCD document should include signed clinical notes or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The 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.

The 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 the Provider does not have a Direct Address, Provider will work with its EMR vendor to set up a Direct Messaging 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 the Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.

Risk Adjustment Data Validation (RADV) audits

As part of the regulatory process, CMS may conduct RADV audits to ensure that the diagnosis data submitted by Molina is complete 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.

Your role as a Provider

As a Provider, complete and accurate documentation in a medical record is critical to a Member's quality of care. We encourage Providers to record all diagnoses to the highest specificity. This will ensure Molina receives adequate resources to provide quality programs to you and to 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 the CMS National Correct Coding Initiative (NCCI).
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a Provider visit with the Member. The visit may be face-to-face or via telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Member's ID and/or group number.
- Have the Provider's signature and credentials.

Contact information

For questions about Molina's Risk Adjustment programs, please contact your Provider Relations Manager.

12. Compliance

Fraud, waste, and abuse

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 that 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, detection, and correction, along with 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 prevent, detect, and correct 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

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care costs 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.
- 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.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment of remuneration to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks—those who offer or pay remuneration—as well as the recipients of kickbacks—those who solicit or receive remuneration.

Molina conducts all business in compliance with federal and state Anti-Kickback Statutes (AKS) statutes and regulations, and federal and state marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKS?

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by federal and state health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKS actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under Molina's policies, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of federal health care program business. Providers must not, directly or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing guidelines and requirements

Providers must conduct all Marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations, both state and federal.

Under Molina's policies, marketing means any communication to a Beneficiary who is not enrolled with Molina, that can reasonably be interpreted as intended to influence the Beneficiary to enroll with Molina's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a Beneficiary to not enroll in or to disenroll from another health plan's products.

Restricted Marketing activities vary from state to state but generally relate to the types and forms of communication that health plans, Providers, and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark Statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare of Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark Law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law (42 U.S.C. § 1395nn).

Sarbanes-Oxley Act of 2002

The Sarbanes-Oxley Act 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—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—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—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 costs 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:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship (Stark Law).
- Altering claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance-billing a Molina 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 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 Member identification (ID) 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:

- Benefit sharing with persons not entitled to the Member's 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 claim system

Molina's Claims team is trained to recognize unusual billing practices, which is key in identifying fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive, or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance AlertLine/reporting repository.

The claims payment system utilizes system edits and flags to validate that 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 of fraud, waste, and abuse detection activities

Through the 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 prepayment 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, federal Centers for Medicare & Medicaid Services (CMS) guidelines, American Medical Association (AMA), and published specialty-specific coding rules. Code edit rules are based on information received from the National Physician Fee Schedule (NPFS) relative file, the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), 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 the 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 and accurate support.

Post-payment recovery activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement with Molina 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 with Molina or at law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider's Agreement with Molina, the parties agree that Molina shall, at its sole

discretion, exercise the terms that are expressed in the Provider's Agreement with Molina, the terms that are expressed here, its rights under law and equity, or some combination thereof.

The Provider will provide Molina, and governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, at Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement with Molina, including for the purpose of investigating potential fraud, waste, and/or abuse. Documents and records must be readily accessible at the location where the 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 the Provider's records, all of the claims for which the Provider received payment from Molina are immediately due and owing. If the 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 the Provider. The Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which the Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

The Provider acknowledges that the Health Insurance Portability and Accountability Act (HIPAA) specifically permits a covered entity, such as the Provider, to disclose Protected Health Information (PHI) for its own payment purposes (see 45 CFR 164.502 and 45 CFR 164.501). The Provider further acknowledges that in order to receive payment from Molina, the 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 the Provider under HIPAA and other applicable privacy laws.

Claim auditing

Molina shall use established industry claim 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.

The Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. The 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, the Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation 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 reserves the right and, where unprohibited by regulation, to 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 extrapolated 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 fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should the Provider refuse to allow access to its facilities, Molina reserves the right to recover the full amount paid or due to the Provider.

Provider education

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

Suspected cases of fraud, waste, or abuse must be reported 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 reporting is available 24/7 year-round. When a report is made, callers can choose to remain confidential or anonymous. When calling the Molina AlertLine, a trained professional at NAVEX Global will note the caller's concerns and provide them to the Molina Compliance department for follow-up. When electing to use the web-based reporting process, a series of questions will be asked before the submission of the report. Reports to the Molina AlertLine can be made from anywhere within the United States with telephone or internet access.

The Molina AlertLine can be reached at **(866) 606-3889** or the service's website at MolinaHealthcare.alertline.com. Fraud, waste, and abuse cases may also be reported to Molina's Compliance department anonymously without fear of retaliation.

Molina Healthcare of Illinois, Inc.
Attn: Compliance

2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Phone: (888) 858-2156

Include the following information when reporting:

- Nature of complaint.
- The names of individuals and/or entities involved in suspected fraud, waste, 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 the state at:

Illinois Attorney General
Online: hfs.illinois.gov/oig/reportfraud.html

Suspected fraud and abuse may also be reported directly to CMS:

Phone: (800) MEDICARE [(800) 633-4227]
or
Office of Inspector General
Attn: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

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 (Health Insurance Portability and Accountability Act) requirements and information

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

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, no comprehensive regulatory framework exists that protects all health information in the United States; instead, Providers must comply with a patchwork of laws. In general, most health care Providers are subject to various laws and regulations pertaining to the privacy of health information, including, without limitation:

1. **Federal Laws and Regulations:**
   - HIPAA (Health Insurance Portability and Accountability Act).
   - 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 of standards for patient privacy, but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Artificial intelligence

Providers shall comply with all applicable state and federal laws and regulations related to Artificial Intelligence (AI) and the use of Artificial Intelligence tools. Artificial Intelligence or AI means a machine-based system that can—with respect to a given set of human-defined objectives, input, or prompt, as applicable—make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to Molina Members including, but not limited to utilization management, Prior Authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician.

In addition, the Provider shall not use AI-generated voice technology, including but not limited to AI voice bots, voice cloning, or synthetic speech systems to initiate or conduct outbound communications to Molina. The prohibition includes, but is not limited to, communications for billing, eligibility verification, Prior Authorization, or any other administrative function.

Notwithstanding the foregoing, the Provider shall give advance written notice to your Molina Contract Manager for any AI used by the Provider that may impact the provision of Covered Services to Molina Members that describes (i) the Providers' use of the AI tool(s) and (ii) how

the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by Molina, the Provider further agrees to (i) allow Molina to audit Providers' AI use, as requested by Molina from time to time, and (ii) to cooperate with Molina with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Molina Members.

If you have additional questions, please contact your Molina Contract Manager.

Uses and disclosure 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 its own Treatment, Payment, and 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:

- A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2].
- A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
    - Quality improvement.
    - Disease management.
    - Care management and care coordination.
    - Training programs.
    - 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.

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

Confidentiality of Substance Use Disorder (SUD) patient records

Federal Confidentiality of Substance Use Disorder Patient Records under 42 USC § 290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2") apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. "SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 CFR Part 2. Providers that are Part 2 Programs must comply with the requirements of 42 CFR Part 2, as amended from time to time.

SUD Records are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects Substance Use Disorder information, 42 CFR Part 2 is more restrictive than HIPAA and does not allow disclosure without the patient's written consent except as set forth in 42 CFR Part 2. Any disclosure of SUD Records to Molina with the written consent of the patient, by a Provider that is a Part 2 Program, must meet the notice requirements of 42 CFR Part 2, specifically Sections 2.31 and 2.32, and shall include a copy of the patient's consent or a clear explanation of the scope of the consent provided.

Providers that are Part 2 Programs pursuant to 42 CFR Part 2 must promptly inform Molina that they are a Part 2 Program.

Inadvertent disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose Protected Health Information (PHI) pertaining to Molina Member(s) who are not the patient(s) 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 nondisclosure of any such misdirected PHI upon the reasonable request of Molina.

Written authorizations

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

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:

- **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.
- **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.

- **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.

- **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.

- **Request to amend PHI**

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

- **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.

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 cybersecurity 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 **strongly encouraged** to submit claims and other transactions to Molina via electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule, including but not limited to:

- 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 MolinaMarketplace.com for additional information regarding HIPAA standard transactions on the HIPAA Transactions and HIPAA Code Sets pages.

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 and Atypical Providers

Providers that are delegated for claims and utilization management activities (Delegated Providers) are the "Business Associates" of Molina for the delegated functions performed on behalf of Molina. Providers that provide services to Molina Members but who are not health care Providers under HIPAA (Atypical Providers) are the Business Associates of Molina. Under HIPAA, Molina must obtain contractual assurances from all Business Associates that they will safeguard Molina Member PHI. Delegated Providers and Atypical Providers must agree to various contractual provisions required under HIPAA's Privacy and Security rules, including entering into a Business Associate Agreement with Molina. Delegated Providers and Atypical Providers agree to comply with the following HIPAA Business Associate Agreement requirements.

HIPAA Required Business Associate Agreement

Applicability: This HIPAA Required Business Associate Agreement (BAA) sets forth the requirements with which the Business Associate must comply when it receives or has access to Protected Health Information (PHI) in the performance of services under the Agreement(s) and with respect to that PHI.

1. DEFINITIONS

Unless otherwise provided for in this BAA, terms used in this BAA shall have the same meanings as set forth in the HIPAA Rules including, but not limited to the following: "Availability," "Confidentiality," "Covered Entity," "Data Aggregation," "Designated Record Set," "Health Care Operations," "Integrity," "Minimum Necessary," "Notice of Privacy Practices," "Required By Law," "Secretary," and "Subcontractor." Specific definitions are as follows:

"**Breach**" shall have the same meaning as the term "breach" at 45 CFR 164.402.

"**Business Associate**" shall have the same meaning as the term "Business Associate" at 45 CFR 160.103 and in reference to the party to this BAA, shall mean the Provider subject to this BAA.

"**Compliance Date**" shall mean, in each case, the date by which compliance is required under the referenced provision of the HIPAA, the HITECH Act or the HIPAA Rules, as applicable; **provided that**, in any case for which that date occurs prior to the effective date of this BAA, the Compliance Date shall mean the effective date of this BAA.

"**Covered Entity**" or "Molina" shall mean Molina Healthcare of Illinois.

"**Electronic Protected Health Information**" or "**Electronic PHI**" shall have the same meaning as the term "electronic protected health information" at 45 CFR 160.103.

"**HIPAA Rules**" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"**Party or Parties**" shall mean Covered Entity and Business Associate who parties to this BAA.

"**Protected Health Information**" or "**PHI**" shall have the same meaning as the term "protected health information" at 45 CFR 160.103.

"**Privacy Rule**" means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

"**Security Incident**" shall have the same meaning as the term "security incident" at 45 CFR 164.304.

"**Security Rule**" means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"**Services**" shall mean, to the extent and only to the extent they involve the creation, use, maintenance, transmission, or disclosure of PHI, the services provided by the Business Associate to Molina under the Agreement(s), including those set forth in this BAA, as amended by written consent of the parties from time to time.

"**SUD Records**" means PHI that includes substance use disorder treatment information that is protected under 42 USC §290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2").

"**Unsecured PHI**" shall have the same meaning as the term "unsecured Protected Health Information" at 45 CFR 164.402.

2. GENERAL PROVISIONS

2.1. **Effect.** This BAA supersedes any prior business associate agreement between the Parties and those portions of any Agreement between the Parties that involve the disclosure of PHI by Molina to Business Associate. To the extent any conflict or inconsistency between this BAA and the terms and conditions of any Agreement exists, the terms of this BAA shall prevail.

2.2. **Amendment**. Molina may, without Business Associate's consent, amend this BAA to maintain consistency and/or compliance with any state or federal law, policy, directive, regulation, or government sponsored program requirement, upon forty-five (45) business days' notice to the Business Associate unless a shorter timeframe is necessary for compliance. Molina may otherwise materially amend this BAA only after forty-five (45) business days prior written notice to the Business Associate and only if mutually agreed to by the Parties as evidenced by the amendment being executed by each Party hereto. If the Parties fail to execute a mutually agreeable amendment within forty-five (45) days of the Business Associate's receipt of Molina's written notice to amend this BAA, Molina shall have the right to immediately terminate this BAA and any Agreement(s) between the Parties which may require the Business Associate's use or disclosure of PHI in performance of services described in such Agreement(s) on behalf of Molina.

3. SCOPE OF USE AND DISCLOSURE

3.1. The Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under the Agreement(s), if such use or disclosure of PHI would not violate the Privacy Rule.

3.2. The Business Associate may not use or further disclose PHI in a manner that would violate the Privacy Rule if done by Molina, except that the Business Associate may use or disclose PHI as necessary:

a. for the proper management and administration of the Business Associate as provided in Section 3.3; and

b. to provide Data Aggregation services relating to the Health Care Operations of Molina if required under the Agreement.

3.3. The Business Associate may use or disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Any disclosures of PHI under this section may be made only if:

a. the disclosures are required by law, or

b. the Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3.4. The Business Associate shall not request, use or release more than the Minimum Necessary amount of PHI required to accomplish the purpose of the use or disclosure and shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date. The Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, Molina, is as between the Parties, the sole property of Molina.

3.5. The Business Associate or its Agents or Subcontractors shall not perform any work outside the United States of America that involves access to, use of, or disclosure of, PHI without the prior written consent of Molina in each instance. Further, the Business Associate or its agents or Subcontractors shall not transmit or store PHI outside of the United States of America without Molina's prior written consent.

3.6. The Business Associate agrees to be fully bound by the requirements of 42 CFR Part 2 upon receipt of any SUD Records disclosed under this Agreement. The Business Associate shall not use or disclose SUD Records except as necessary for the Business Associate to perform Services. The Business Associate shall not redisclose any SUD Records to a third party, except to a contract agent acting on the Business Associate's behalf to provide Services or back to Molina. The contract agent may only redisclose such information to the Business Associate or Molina. The Business Associate and any contract agent shall not disclose SUD Records for use in any civil, criminal, administrative or legislative proceeding against the individual who is the subject of the SUD Record and shall immediately notify Molina of any such request. The Business Associate must ensure that any such contract agent agrees in writing to these same restrictions and obligations set forth in this Section.

4. OBLIGATIONS OF THE BUSINESS ASSOCIATE

The Business Associate shall:

4.1. Not use or disclose PHI other than permitted or required by this BAA or as Required by Law.

4.2. Establish and use appropriate safeguards to prevent the unauthorized use or disclosure of PHI.

4.3. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of Molina. The Business Associate shall, as of the Compliance Date, comply with the applicable standards at Subpart C of 45 CFR Part 164.

4.4. Promptly report to Molina any unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, within no more than five (5) days, after Business Associate becomes aware of the unauthorized use or disclosure of PHI, Breach of Unsecured PHI or Security Incident. The Business Associate shall take all reasonable steps to mitigate any harmful effects of such unauthorized use or disclosure, Breach of Unsecured PHI, or Security Incident. The Business Associate shall indemnify Molina against any losses, damages, expenses or other liabilities including reasonable

attorney's fees incurred as a result of the Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, including, but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI and the provision of two years of credit monitoring and identity protection services to the affected individuals. Indemnification is subject to an ability to demonstrate that no agency relationship exists between the parties.

4.5. The Business Associate shall, following discovery of a Breach of Unsecured PHI, notify Molina of such Breach as required at 45 CFR 164.410, without unreasonable delay, and in no event more than thirty (30) days after the discovery of the Breach. The notification by the Business Associate to Molina shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that Molina is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;
b. a description of the types of Unsecured PHI that were involved in the Breach; and
c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

4.7. Within ten (10) days of receiving a request, make available PHI in a Designated Record Set to Molina as necessary to satisfy Molina's obligations under 45 CFR 164.524.

4.8. Within fifteen (15) days of receiving a request, make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by Molina pursuant to 45 CFR 164.526.

4.9. Maintain and make available to Molina, within twenty (20) days of receiving a request, the information required to provide an accounting of disclosures to the individual as necessary to satisfy Molina's obligations under 45 CFR 164.528.

4.10. Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of Molina available to Molina or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

4.11. To the extent the Business Associate conducts Standard Transaction(s) (as defined in the HIPAA Rules) on behalf of Molina, Business Associate shall comply with the HIPAA Rules, "Administrative Requirements," 45 C.F.R. Part 162, by the applicable compliance date(s) and shall not: (a) change the definition, data condition or use of a

data element or segment in a standard; (b) add any data elements or segments to the maximum defined data set; (c) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) change the meaning or intent of the standard's implementation specifications. The Business Associate shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under subsection (h) of Title 42 U.S.C. Section 1320d-2.

4.12. To the extent the Business Associate is to carry out one or more of Molina's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to Molina in the performance of such obligation(s).

5. MISCELLANEOUS

5.1. **Indemnification**. In addition to any indemnities set forth in the Agreement(s), each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation expressly contained herein by such party, its employees, agents, Subcontractors or other representatives.

5.2. **Interpretation**. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

5.3. **No Third Party Beneficiaries**. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

5.4. **Governing Law and Venue**. This BAA shall be governed by Illinois state law notwithstanding any conflicts of law provisions to the contrary. The venue shall be the jurisdiction where the applicable services were received by Molina.

5.5. **Compliance with Confidentiality Laws**. The Business Associate acknowledges that it must comply with all applicable laws that may protect the confidentiality of PHI or other personally identifiable information received and will comply with all such laws.

5.6. **Notices**. Any notices to be given hereunder to Molina shall be made via certified U.S. Mail or express courier to Molina's address given below, and/or (other than for the delivery of fees) via email to the email listed below:

Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

Attn: Privacy Official
Email: PrivacyOfficial@MolinaHealthcare.com

6. TERM AND TERMINATION OF BAA

6.1. **Term**. The Term of this BAA shall be effective as of the effective date set forth in the first paragraph of this BAA, and shall terminate on date that the last Agreement remaining in force between the parties is terminated or expires, or on the date Molina terminates for cause as authorized in paragraph 6.2 below, whichever is sooner.

6.2. **Termination for Cause**. Notwithstanding any other provision of this BAA or the Agreement(s), Molina may terminate this BAA and any or all Agreement(s) upon five (5) days written notice to Business Associate if Molina determines, in its sole discretion, that Business Associate has violated a material term of this BAA.

6.3. **Obligations of Business Associate Upon Termination**. Upon termination of this BAA for any reason, Business Associate shall return to Molina or, if agreed to by Molina, destroy all PHI received from Molina, or created, maintained, or received by Business Associate on behalf of Molina, that the Business Associate still maintains in any form. If PHI is destroyed, Business Associate agrees to provide Molina with certification of such destruction. Business Associate shall not retain any copies of PHI except as Required by Law. If return or destruction of all PHI, and all copies of PHI, received from Molina, or created, maintained, or received by Business Associate on behalf of Molina, is not feasible, Business Associate shall:

a. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section 6, for as long as Business Associate retains the PHI; and

b. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 3 above which applied prior to termination.

6.4. **Survival**. The obligations of Business Associate under this Section shall survive the termination of this BAA and remain in force as long as Business Associate stores or maintains PHI in any form or format (including archival data). Termination of the BAA shall not affect any of the provisions of this BAA that, by wording or nature, are intended to remain effective and to continue in operation.

Reimbursement for copies of PHI

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

- Utilization management.
- Care coordination and/or complex medical care management services.
- Claims review.
- Resolution of an appeal and/or grievance.
- Anti-fraud program review.
- Quality of care issues.
- Regulatory audits.

- Risk adjustment.
- Treatment, payment and/or operation purposes.
- Collection of HEDIS® medical records.

Information security and cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by Molina to perform a health plan function(s), and in connection with such delegated functions.

1. **Definitions**:

   (a) **Molina information**—Any information: (i) provided by Molina to Provider; (ii) accessed by Provider or available to Provider on Molina's Information Systems; or (iii) any information with respect to Molina or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Molina Nonpublic Information.

   (b) **Cybersecurity event**—Any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition, or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized, or unlawful destruction, loss, alteration, use, disclosure of, or access to Molina Information. For clarity, a Breach or Security Incident, as these terms are defined under HIPAA, constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which 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, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition, or disclosure of Molina Information, or sustained interruption of service obligations to Molina.

   (c) **HIPAA**—The Health Insurance Portability and Accountability Act, as may be amended from time to time.

   (d) **HITECH**—The Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

   (e) **Industry standards**—As applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time, and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

      i. HIPAA and HITECH
      ii. HITRUST Common Security Framework

iii. Center for Internet Security
iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1, or as currently revised
v. Federal Information Security Management Act ("FISMA")
vi. ISO/ IEC 27001
vii. Federal Risk and Authorization Management Program ("FedRamp")
viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."
ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) **Information systems**—All computer hardware, databases and data storage systems, computer, data, database, and communications networks (other than the internet), cloud platform, architecture interfaces, and firewalls (whether for data, voice, video or other media access, transmission, or reception), and other apparatus used to create, store, transmit, exchange, or receive information in any form.

(g) **Multi-factor authentication**—Authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h) **Nonpublic information** includes:
i. Molina's proprietary and/or confidential information;
ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information," or any other similar term as defined pursuant to any applicable law; and
iii. Protected Health Information as defined under HIPAA and HITECH.

2. **Information security and cybersecurity measures**. Provider shall implement and, at all times maintain, appropriate administrative, technical, and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon, and Molina Information accessible to, or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices, and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical, and physical safeguards pursuant to HIPAA, HITECH, and other applicable U.S. federal, state, and local laws.

(a) **Policies, procedures, and practices**. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards, and standards, including, as applicable, a written

information security program, which Molina shall be permitted to audit via written request, and which shall include at least the following:

i. **Access controls**. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and Molina Information accessible to or held by Provider.

ii. **Encryption**. Use of encryption to protect Molina Information, in transit and at rest, accessible to or held by Provider.

iii. **Security**. Safeguarding the security of the Information Systems and Molina Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third-party vulnerability assessments, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

iv. **Software maintenance**. Software maintenance, support, updates, upgrades, third-party software components, and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.

(b) **Technical standards**. Provider shall comply with the following requirements and technical standards related to network and data security:

i. **Network security**. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

ii. **Cloud services security**. If Provider employs cloud technologies, including Infrastructure as a Service (IaaS), Software as a Service (SaaS) or Platform as a Service (PaaS), for any services, Provider shall adopt a "zero-trust architecture," satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. **Data storage**. Provider agrees that any and all Molina Information will be stored, processed, and maintained solely on designated target servers or cloud resources. No Molina Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. **Data encryption**. Provider agrees to store all Molina Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all Molina Information stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a

128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. **Data transmission**. Provider agrees that any and all electronic transmission or exchange of system and application data with Molina and/or any other parties expressly designated by Molina shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Reuse requirements set forth herein.

vi. **Data reuse**. Provider agrees that any and all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Provider. Provider further agrees that no Molina Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Molina.

3. **Business Continuity ("BC") and Disaster Recovery ("DR")**. Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade, or disrupt Provider's delivery of services to Molina.

(a) **Resilience questionnaire**. Provider shall complete a questionnaire provided by Molina to establish Provider's resilience capabilities.

(b) **BC/DR plan**.

(i) Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format (**BC/DR plan**). The BC/DR Plan shall identify the service level agreement(s) established between Provider and Molina. The BC/DR Plan shall include the following:

a) Notification, escalation, and declaration procedures.
b) Roles, responsibilities, and contact lists.
c) All Information Systems that support services provided to Molina.
d) Detailed recovery procedures in the event of the loss of people, processes, technology, and/or third-parties or any combination thereof providing services to Molina.
e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.
f) Detailed list of resources to recover services to Molina, including but not limited to applications, systems, vital records, locations, personnel, vendors, and other dependencies.

g) Detailed procedures to restore services from a Cybersecurity Event, including ransomware.

h) Documented risk assessment, which shall address and evaluate the probability and impact of risks to the organization and services provided to Molina. Such risk assessment shall evaluate natural, human-made, political, and cybersecurity incidents.

(ii) To the extent that Molina Information is held by Provider, Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.

(iii) Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c) **Notification**. Provider shall notify Molina's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed twenty-four (24) hours, of either of the following:

i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Molina or that detrimentally affects Provider's Information Systems or Molina's Information.

ii. Provider's activation of business continuity plans. Provider shall provide Molina with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.

(d) **BC and DR testing**. For services provided to Molina, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide Molina a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercise(s).

4. **Cybersecurity events**.

(a) Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to, and resolve Cybersecurity Events.

(b) In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems), Provider's Information Systems, or Molina Information accessible to or held by Provider, Provider shall notify Molina's Chief

Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than 24 hours from Provider's discovery of the Cybersecurity Event.

i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within 24 hours following such payment.

ii. Within 15 days of such a ransom payment that involves or may involve Molina Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment, and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

(c) Notification to Molina's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer
Phone: 844-821-1942
Email: CyberIncidentReporting@molinahealthcare.com

Molina Chief Information Security Officer
Molina Healthcare of Illinois, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

(d) In the event of a Cybersecurity Event, Provider will, at Molina's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Molina; (ii) fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers; and (iii) be liable for any expenses associated with the Cybersecurity Event including, without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law), and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Molina Information without the prior written consent of Molina.

(e) Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation or, upon request by Molina, complete an investigation pursuant to the following requirements:

i. make a determination as to whether a Cybersecurity Event occurred;

ii. assess the nature and scope of the Cybersecurity Event;

iii. identify Molina's Information that may have been involved in the Cybersecurity Event; and

iv. 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 Molina Information.

(f) Provider must provide Molina the following required information regarding a Cybersecurity Event 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 must include at least the following, to the extent known:

i. the date of the Cybersecurity Event;
ii. a description of how the information was exposed, lost, stolen, or breached;
iii. how the Cybersecurity Event was discovered;
iv. whether any lost, stolen, or breached information has been recovered and, if so, how this was done;
v. the identity of the source of the Cybersecurity Event;
vi. 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;
vii. a description of the specific types of information accessed or 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;
viii. the period during which the Information System was compromised by the Cybersecurity Event;
ix. the number of total consumers in each State affected by the Cybersecurity Event;
x. 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;
xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
xii. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and
xiii. the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

(g) Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event, or such longer period as required by applicable laws, and produce those records upon Molina's request.

5. **Right to conduct assessments; provider warranty**. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Molina performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement will be in compliance with generally recognized industry standards and as provided in Provider's response to Molina's due diligence/security risk assessment questionnaire; (ii) agrees to inform Molina promptly of any material variation in operations from what was provided in Provider's response to Molina's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to Molina's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement.

6. **Other provisions**. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between Molina and Provider, but are not contained in this section.

7. **Conflicting provisions**. In the event of any conflict between the provisions of this section and any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

13. Claims and Compensation

Molina Payer ID	20934
Availity Essentials portal	Availity Essentials portal
Clean Claim Timely Filing	180 Days

Electronic claim submission

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

- Reducing operations costs associated with paper claims (printing, postage, etc.).
- Increasing accuracy of data and efficient information delivery.
- Reduces claim delays since errors can be corrected and resubmitted electronically.
- Eliminating mailing time so claims reach Molina faster.

Molina offers the following electronic claims submission options:

- The Availity Essentials portal.
- Your regular EDI clearinghouse using **Payer ID 20934**.

Availity Essentials portal

The Availity Essentials portal is a **no-cost** online platform that offers several claim-processing features:

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB-04]) 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.
- Manage overpayment invoices (Inquire, Dispute, Resolve)

Clearinghouse

Molina uses the SSI Group as its gateway clearinghouse. The SSI Group has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit claims to their usual clearinghouse.

If you do not have a clearinghouse, Molina offers additional electronic claims submission options, as shown by logging on to the Availity Essentials portal.

Molina accepts EDI transactions through our gateway clearinghouse for claims via 837P for Professional and 837I for Institutional. It is important to track your electronic transmissions

using your acknowledgement reports. The reports assure that 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 claim from your clearinghouse.
- You should refer to the Molina Companion Guide for information on the response format and messages.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

EDI claim 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 should contact their Provider Relations Manager 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 the 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, the Provider must submit claims to Molina within 90 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 the 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 through a clearinghouse or the Availity Essentials portal whenever possible and use current HIPAA-compliant American National Standards Institute (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 Molina Member's 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 the date of discharge for inpatient facility claims.

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. Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Molina may validate the NPI submitted in a claim transaction is a valid NPI and is recognized as part of the NPPES data.

Required elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting to or receiving files from Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website at EDI tab, "Companion Guides" for regularly updated information regarding Molina's companion guide requirements. Note: Remember to choose Illinois from the drop-down list at the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the Illinois-specific companion guides, which are also available on the website for your convenience.

Electronic claim submissions will adhere to specifications for submitting medical claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for compliance with Strategic National Implementation Process (SNIP) levels 1-7.

The following information **must** be included on **every** claim, whether electronic or paper:

- Member name, date of birth.
- 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).
- Ten (10)-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API).
- Ten (10)-digit National Provider Identifier (NPI) of the Billing Provider or Group.
- Rendering Provider information when different from billing.
- Billing/pay-to Provider name and billing address.
- Place of service and type (for facilities).

- Disclosure of any other health benefit plans.
- National Drug Code (NDC), NDC Units, Units of Measure, and Days or Units for medical injectables.
- E-signature.
- Service facility location information.
- Any other state-required data.

Provider and Member data will be verified for accuracy and active status. Providers must validate this data in advance of claim submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers. Inaccurate, incomplete, or untimely submissions and resubmissions may result in denial of the claim.

EDI (clearinghouse) submission

Corrected claim information submitted via EDI submission must follow electronic claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for compliance with SNIP levels 1–7. The 837 claim format allows you to submit changes to claims that were not included in the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "claim frequency codes." Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted finalized claim. Use the frequency codes in the table below for claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace an entire claim.	Molina will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
8	Use to eliminate a previously submitted claim.	Molina will void the original claim from records based on request.

When submitting claims noted with claim frequency code 7 or 8, the original claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original claim number, adjustment requests will generate a compliance error and the claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate, and the original claim number will not be adjusted.

Paper claim submission

Participating Providers should submit claims electronically. If electronic claim submission is not possible, you may submit paper claims to:

Molina Healthcare of Illinois, Inc.
PO Box 540
Long Beach, CA 90806

When submitting paper claims:

- Paper claim submissions are not considered to be "accepted" until received at the appropriate claims P.O. Box. Claims received outside of the designated P.O. Box will be returned for appropriate submission.
- Paper claims **must** be submitted on original red-and-white CMS-1500 and CMS-1450 (UB-04) claim forms.
- Paper claims not submitted on the required forms will be rejected and returned. This includes black-and-white forms, copied forms, and any altering to include claims with handwriting.
- Claims must be typed with either 10 or 12-point Times New Roman font, using black ink.
- Link to paper claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

Corrected claim process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms. Molina **strongly encourages** Providers to submit corrected claims electronically via EDI or in the Availity Essentials portal (preferred method). All corrected claims must:

- Be free of handwritten or stamped verbiage (paper claims).
- Be submitted on a standard red CMS-1450 (UB-04) or CMS-1500 claim form (paper claims).
- Include the original claim number in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 (paper claim), or the applicable 837 transaction loop for submitting corrected claims electronically.
- Include the appropriate frequency code/resubmission code in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the National Uniform Claim Committee (NUCC) manual for CMS-1500 claim forms or the Uniform Billing (UB) Editor for CMS-1450 (UB-04) claim forms.

Corrected claims must be sent within 180 calendar days of the most recent adjudicated date of the claim. Corrected claims submission options:

- Submit corrected claims directly to Molina via the Availity Essentials portal.
- Submit corrected claims to Molina via your regular EDI clearinghouse.

Important: Claims submitted without the correct coding will be returned to the Provider for resubmission.

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

Our benefit plans are subject to subrogation and COB rules.

Subrogation—Molina retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under state and federal law and the Member's benefit plan. If third-party liability is suspected or known, please refer pertinent case information to Molina's vendor, Katch IQ, at submitreferrals@katchiq.com.

COB—Coordination of Benefits (COB) exists when an individual has more than one policy at the same time and order of benefits are established pursuant to national and/or state guidelines. Primary payers should be billed prior to claim submission to secondary/tertiary payers to cover any remaining liability.

Workers' compensation—Workers' compensation is primary payer when a Member's damages are related to an incident that occurred while working. Claims related to a workers' compensation incident should be submitted to the carrier prior to submitting to Molina for payment.

Medicare—Medicare is the primary payer for covered services and providers accepting Medicare assignment except in the following instances:

- Members entitled to Medicare due to age: Commercial health plans are primary to Medicare if the employer has 20 or more employees and the Member is actively working.
- Disabled employees (large group health plan): Commercial health plans are primary to Medicare if the employer has 100 or more employees and the Member is actively working.
- **End-Stage Renal Disease (ESRD)**—If a Member is entitled to Medicare due to ESRD while covered under an employer's group health plan, commercial group health plan is primary for the first 30 months after becoming eligible for Medicare. After the 30 months, Medicare is the primary payer. However, if the commercial group health plan was secondary to Medicare when the Member became entitled due to ESRD, Medicare will remain the primary payer and no 30 month coordination period is required.

Hospital-Acquired Conditions (HAC) and Present on Admission (POA) 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 evidence-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:

- Foreign object retained after surgery.
- Air embolism.
- Blood incompatibility.
- Stage III and IV pressure ulcers.
- Falls and trauma:
  - Fractures.
  - Dislocations.
  - Intracranial injuries.
  - Crushing injuries.
  - Burn.
  - Other injuries.
- Manifestations of poor glycemic control:
  - Hypoglycemic coma.
  - Diabetic ketoacidosis.
  - Nonketotic hyperosmolar coma.
  - Secondary diabetes with ketoacidosis.
  - Secondary diabetes with hyperosmolarity.
- Catheter-associated Urinary Tract Infection (UTI).
- Vascular catheter-associated infection.
- Surgical-site infection, mediastinitis, following coronary artery bypass graft (CABG).
- Surgical-site infection following bariatric surgery procedures for obesity:
  - Laparoscopic gastric bypass.
  - Gastroenterostomy.
  - Laparoscopic gastric restrictive surgery.
- Surgical-site infection following certain orthopedic procedures:
  - Spine.
  - Neck.
  - Shoulder.
  - Elbow.
- Surgical-site infection following Cardiac Implantable Electronic Device (CIED).
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following certain orthopedic procedures:
  - Total knee replacement.
  - Hip replacement.
- Iatrogenic pneumothorax with venous catheterization.

What this means to Providers

Acute Inpatient Prospective Payment System (IPPS) Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing.

No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

For additional information regarding the Medicare HAC/POA program, including billing requirements, please refer to the CMS website at 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 MolinaMarketplace.com website under the Policies tab. Questions can be directed to your Provider Relations Manager.

Reimbursement guidance and payment guidelines

Providers are responsible for the submission of accurate claims. Molina requires coding of both diagnoses and procedures for all claims.

- **For diagnoses**—The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- **For services**:
  - **Professional and outpatient claims**—The Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes).
  - **Inpatient hospital claims**—The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) coding schemes.

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 claim adjudication system that encompasses edits and audits that follow federal requirements, and administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to:

- 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). If a professional organization has a more stringent/restrictive standard than a federal MUE, the professional organization standard may be used.
  - Medicare National Coverage Determinations (NCD).
  - 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 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 in accordance with applicable billing guidelines.

For guidance, refer to Molina's Telemedicine, Telehealth Services, and Virtual Visits policy.

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 uses NCCI standard payment methodologies.

NCCI procedure-to-procedure edits prevent inappropriate payment of services that should not be bundled or billed together and promote correct coding practices. Based on the 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 the 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 prevents 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 (DOS). 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. 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 (2) 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 (1) 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 the 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 (POS) codes are two (2)-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 code 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 (4)-digit alphanumeric code that gives three (3) 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 CMS-1450 (UB-04) Data Specifications Manual.

Revenue codes

Revenue codes are four (4)-digit codes used to identify specific accommodation and/or ancillary charges. Certain revenue codes require CPT/HCPCS codes to be billed. For a

complete list of codes, reference the NUBC's Official CMS-1450 (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 National Drug Code (NDC) number must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, CMS-1450 (UB-04), or the electronic equivalent.

Providers **must** submit claims with both HCPCS and NDC codes with the exact NDC number that appears on the medication packaging in the "5-4-2 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. It has three (3) 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 (DME) 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 and Prevention (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.

The Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. The 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, the Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. 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 reserves the right, and where unprohibited by regulation, to 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 extrapolated 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 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.

Timely claim processing

Claim processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider Agreement with Molina. 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 within 30 days after receipt of clean claims.

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, provide

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 MolinaMarketplace.com or by contacting the Molina Provider Services.

Overpayments and incorrect payment refund requests

In accordance with 42 CFR 438.608, Molina requires network Providers to report to Molina when they have received an overpayment and to return the overpayment to Molina within 60 calendar days after the date on which the overpayment was identified and notify Molina in writing of the reason for the overpayment.

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 in accordance with state and CMS guidelines if the overpayment is identified. Providers will be given the option to:

- Submit a refund to satisfy overpayment.
- Submit a request to offset from future claim payments.
- Dispute overpayment findings.

Copies of the overpayment request letter and details are available in the Availity Essentials portal. In the Overpayment Application section, Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment, or check status. **Note**: This is Molina's preferred method of communication.

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

Overpayments related to Third-Party Liability Coordination of Benefits (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.

For Members with Medicare COB, Molina will provide notice within 540 days from the claim's paid date if the primary insurer is a Medicare 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 time

frame 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 disputes/reconsiderations/appeals

Information on claim disputes/reconsiderations/appeals is located in the Provider Disputes and Complaints, and Enrollee Appeal and Grievance Processes section of this Provider Manual.

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 Member for Covered Services is prohibited**, except for the Member's applicable copayment, coinsurance, and/or deductible amounts. Please refer to the Provider Responsibilities section of this Provider Manual.

Fraud, waste, and abuse

Failure to report instances of suspected fraud, waste, 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, risk adjustment, hospital rate setting, the Quality Improvement program, and HEDIS® reporting.

Encounter data must be submitted at least once per month and within 365 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 for Institutional, 837P for Professional, and 837D for 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 that are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within 15 days of the rejection/denial.

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

When encounters are filed electronically, Providers should receive two (2) types of responses:

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

Molina's Marketplace payment rate

Molina's Marketplace payment rate does not include any add-on payments, adjustments, or deductions that are only allowed for a Medicare Member, including but not limited to:

- Uncompensated Disproportionate Share Hospital (DSH) payments.
- Operating and capital DSH payments.
- Operating and capital Indirect Medical Education (IME) payments.
- Direct graduate medical education expense payments.
- Deductions for sequestration.

14. Provider Disputes and Complaints, and Enrollee Appeal and Grievance Processes

Provider claim dispute process

Providers disputing a claim previously adjudicated must request such action within 90 calendar days of Molina's original remittance advice date. Regardless of the type of denial/dispute (service denied, incorrect payment, administrative, etc.), all claim disputes must be submitted on the Molina Appeals Form found on the Provider website, which can be found at Provider Claims Dispute Request Form and the Availity Essentials portal. The form must be filled out completely to be processed. Additionally, the item(s) being resubmitted should be clearly marked as an appeal and must include the following:

- Provider's name
- Date of service
- Date of billing
- Date of payment and/or non-payment
- Member's name
- Claim number (Services cannot be appealed without a claim on file)
- Member ID number
- The reason(s) the claim merits reconsideration. If the appeal relates to a medical emergency, Medical Necessity and/or Prior Authorization, medical records or substantiating documentation must accompany the request for reconsideration, which includes but is not limited to the following:
  - Physician notes
  - Tests and reports
  - Medication lists for the hospital stay
  - Nurse notes
  - Social Worker notes
- The claim number clearly marked on all supporting documents

A request to review the processing, payment, or non-payment of a claim by Molina shall be classified as a Provider claim dispute and can be submitted through one of the following options:

- Availity Essentials portal (preferred)
- **Fax**: Provider claim disputes can be faxed to Molina at **(855) 502-4962**. They must also contain a completed Claims Dispute Request Form.

Note: CDs containing medical records may be sent to:

Molina Healthcare of Illinois, Inc.
Attention: Provider Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422

The Provider **must** include a completed Claims Dispute Request Form **and** the password to the CD file, or the CD will be returned. One claim per dispute form.

A contracted Provider may request reconsideration of a claim on their behalf by submitting a completed Claims Dispute Request Form with supporting documentation as appropriate. The form **must** be completed to document the review request. It can be found the Forms & Documents page of Molina's Provider website.

Molina will have 60 calendar days to process a claims-related dispute request. All requests submitted without appropriate documentation will be denied for lack of information. The Provider will be responsible for providing the appropriate requested documentation within 90 calendar days from the original remittance date. Molina or a regulatory agency may request medical records during the reconsideration process; the Provider shall **not** charge the Enrollee or Molina for requested records submitted for the reconsideration.

Note: Corrected claims are considered new claims and are to be directed through the original claim submission process, clearly identified as a corrected claim. Corrected claims are **not** considered an appeal or dispute and will be rejected.

Provider complaints

Providers have the right to file a complaint if they are dissatisfied with any aspect of operation or service rendered by Molina that **does not** pertain to a benefit or claim determination. Complaints may be submitted no later than 30 calendar days from the date the Provider becomes aware of the issue generating the complaint. Provider complaints can be sent to Molina at:

Fax: (855) 502-4962

Molina Healthcare of Illinois, Inc.
Attention: Provider Complaints Dept.
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Enrollee appeals processes

Molina Enrollees or the personal representatives of Enrollees have the right to file a grievance and submit an appeal through a formal process. All appeals must first be submitted to Molina within 180 days of the Adverse Benefit Determination. Appeals not resolved wholly in the Enrollee's favor can be appealed to the Illinois Department of Healthcare and Family Services (HFS). However, the filing of an appeal does not preclude the Enrollee from filing a complaint with HFS.

This section addresses the identification, review, and resolution of Enrollee's appeal. Molina's Enrollee Appeals Process is as follows. Appeals may be submitted by Enrollees or an authorized representative, such as a family member or the Provider, on behalf of the Enrollee in response to an Adverse Benefit Determination. If the appeal is submitted by someone other than the Enrollee, a signed Molina Healthcare of Illinois Authorized

Representative Designation form must be included with submission. If Molina's decision is to deny a service in whole or part, Enrollees and Providers are notified of the following at the time of denial:

- Their right to appeal the decision.
- The process by which the appeal process is initiated.
- The Molina Member Services phone number, where more information regarding the appeals process can be obtained.
- The availability of the Illinois State Department of Insurance.

Enrollee types of appeals

An Enrollee may request an expedited or standard appeal. Appeals may be filed orally or in writing. Appeals are filed to request that Molina change an adverse determination for care or services submitted by the Enrollee or authorized representative. Appeals may be requested within 180 days of the Adverse Benefit Determination notice.

An expedited appeal request is submitted to the plan for review of an Adverse Benefit Determination if the standard appeal time frame indicates that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Enrollee authorized representative

An Enrollee may appoint an authorized representative to act on their behalf. The representative may be a guardian, caretaker, relative, health care Provider, or an attorney. Any standard appeals requested on behalf of the Enrollee must have written authorization from the Enrollee. If an authorized representative is filing an appeal on behalf of an Enrollee, an Authorized Representative Designation Form must be completed, signed by the Enrollee, and submitted with the appeal request. Molina can provide the form as needed.

Molina will ensure that no punitive action is taken against a Provider who acts as an authorized representative on behalf of the Enrollee or supports an appeal filed by an Enrollee.

Enrollee standard appeals process and timeline

Standard appeals may be received orally or in writing within 180 calendar days following the date of the notice of action. An oral appeal request may be filed by calling Molina's Member Services department. However, all oral appeals must be followed up with a written request signed by the Enrollee. Standard appeal requests submitted in writing should be sent to:

Fax: (855) 502-5128

Molina Healthcare of Illinois, Inc.
Attention: Member Appeals and Grievance

PO Box 182273
Chattanooga, TN 37422

All appeal requests must include the Enrollee's name, address, Member ID number, reasons for appealing, and documentation or evidence such as medical records, physician letters, or other important information that explains the reason the service or item is needed. An Authorized Representative Form should be attached to the request when appropriate on behalf of an Enrollee. An appeal request submitted after the 180-day time frame must provide good cause (such as the Enrollee being seriously ill, preventing the ability to file the appeal) in order for Molina to consider the late request.

Upon receipt of an appeal, Molina will notify the party filing the appeal of all information that is required to evaluate the appeal. A written acknowledgement will be sent to the Enrollee within three (3) business days.

No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal.

Written notifications of the appeal decision will contain reasons for the determination, including the medical or clinical criteria used to make the determination.

Time frames for responding to an appeal

Request Type	Time Frame for Decision
Pre-Service Appeals	Molina will notify the Member in writing of Molina's appeal decision as soon as practical, taking into account the medical circumstances, but not later than 15 business days after Molina's receipt of the Member's appeal.
Post-Service Appeals	Molina will notify the Member in writing of Molina's appeal decision as soon as practical, which generally will not be later than 15 business days after Molina's receipt of all information necessary to complete the appeal. However, in extraordinary circumstances, Molina will have up to 60 calendar days from the date that the Member submits an appeal to provide the Member with notification of Molina's appeal decision.
Expedited Appeals (Urgent Care Service Decisions)	Molina will give the Member oral notice of Molina's appeal decision as soon as possible, considering the medical circumstances, but not later than either of the following time frames: • 24 hours from the time that Molina receives all information necessary to complete the appeal. • 72 hours from Molina's receipt of the Member's appeal.

If the Enrollee is dissatisfied with the outcome of an appeal, the Enrollee or authorized representative may request an external independent review. A request may be made within

four (4) months of receiving the adverse appeal decision. Review will be completed at no cost to the enrollee. To request a review, contact:

Illinois Department of Insurance Office of Consumer
Health Insurance External Review Unit
320 W. Washington Street
Springfield, IL 62767

Phone: (877) 850-4740
Fax: (217) 557-8495
Email: DOI.externalreview@illinois.gov
Online: mc.insurance.illinois.gov/messagecenter.nsf

Enrollee expedited internal appeals process and timeline

Expedited appeals may be received orally or in writing within 180 days from the date of the notice of action. Any requests submitted in writing should be sent to the address or fax number above under the Standard Appeal Process section. Expedited appeal requests on behalf of the Enrollee do not require signed written consent of the Enrollee. A request to expedite an appeal will be considered in situations where applying the standard appeal time frame could seriously jeopardize the Enrollee's life, health, or ability to regain maximum function. An expedited review is not possible when services have already been provided to the Enrollee.

Upon receipt of the appeal, Molina will notify the party filing the appeal as soon as possible, and within no more than 24 hours after receipt of all information that is required to evaluate the appeal.

Molina will render a decision within 24 hours after receiving the required information. If additional information required to make the final appeal determination is not received within 72 hours, a determination will be made with the current information available.

If it is determined the expedited appeal request does not meet expedited criteria, the request will be processed under the standard appeal time frame of 15 business days from the date the request was received.

Molina will orally notify the party filing the appeal, the Enrollee (or designated representative), the Enrollee's PCP, the requesting provider, and any health care provider who recommended the service involved in the appeal, of its decision. Oral notification will be followed up by a written notice of determination within two (2) calendar days following the oral notification.

Please note that expedited review is not available for retrospective adverse or final adverse determinations, per 215 ILCS 180/40(i).

Enrollee external independent review

Enrollees may skip an internal appeal and standard review and request an expedited (quick) appeal in the following instances:

An expedited (quick) appeal is available to Enrollees if their Provider thinks their life or health is in immediate danger. An expedited external independent appeal can be requested orally or in writing. Molina will give the Enrollee oral notice of the appeal decision as soon as possible, considering the medical circumstances, but no later than either of the following time frames: two (2) business days after receipt of all information necessary to complete the appeal; or 24 hours from receipt of the appeal, if Molina has all the information needed to make a decision. A 14-day extension can be made if requested by the Enrollee. Molina can apply a 14-day extension if it is in the best interest of the Enrollee. Enrollee must be notified of the extension.

Once a decision is reached the enrollee will be notified.

An external appeal can be requested when Molina has denied an Enrollee's request for the provision of or payment for a health care service or course of treatment. Enrollees have the right to have Molina's decision reviewed by an independent review organization not associated with Molina by submitting a written request for an external review to:

Department of Insurance
Office of Consumer Health Information
320 West Washington Street, 4th Floor
Springfield, IL 62767

Enrollees can request external review prior to exhausting the Molina internal process, except in regard to appeals of services already provided.

External Appeals can be requested prior to the completion of the internal appeal if:

- The Enrollee has a medical condition wherein the time frame for completion of an internal appeal would seriously jeopardize the Enrollee's life or health, or would jeopardize their ability to regain maximum function.
- If review of the internal appeal has been delayed by Molina by 30 days for concurrent or prospective and 60 days for retrospective.
- If expedited internal appeal has been delayed by Molina for more than 72 hours.
- For experimental/investigational Enrollees may file for an expedited external review if delay of the recommended health service would be significantly less effective if delayed.
- If a final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the Enrollee received emergency services, but have not been discharged from a facility.
- If Molina fails to adhere to the requirements of the appeal process, as outlined above, you may have the right to request external review or other remedies under state law.

Requesting an external review

External reviews will be conducted by an Independent Review Organization (IRO). Molina will not choose or influence the IRO reviewers. Enrollees must request a standard external review within four (4) months of the exhaustion of Molina's internal appeal process. A request for an

expedited (quick) external review has no filing deadline. All requests must be in writing. Molina will initiate the external review by notifying the Department of Insurance, Office of Consumer Health Information of the Enrollee's request, which will assign the IRP to conduct the external review. For standard external review requests, Molina will notify the Enrollee in writing of the assignment to an IRO. Molina will pay the costs of the external review.

For questions about external appeal rights or assistance with the external review process, Enrollees and their representatives may contact:

Illinois Department of Insurance Office of Consumer
Health Insurance External Review Unit
320 W. Washington Street
Springfield, IL 62767

Phone: (877) 850-4740
Fax: (217) 557-8495
Email: DOI.externalreview@illinois.gov
Online: mc.insurance.illinois.gov/messagecenter.nsf

Enrollee grievance process

Molina has an organized grievance process to ensure thorough, appropriate, and timely resolution to an Enrollee's grievances. A grievance is an expression of dissatisfaction that may include, but is not limited to:

- Requests for disenrollment.
- Difficulty finding a Provider.
- Unhappiness with the Prior Authorization process.
- Services provided by Molina staff or Molina Providers.

If an Enrollee is unhappy with Molina or its Providers, they may file a grievance by contacting Member Services or by writing to:

Molina Healthcare of Illinois, Inc.
Attention: Member Appeals and Grievances
PO Box 182273
Chattanooga, TN 37422

Fax: (855) 502-5128

Enrollees are notified of their grievance rights through various general communications including, but not limited to, the Member Handbook, Evidence of Coverage and Disclosure, Member newsletters, and Molina's website.

Enrollees may identify an individual, including an attorney or Provider, to serve as a personal representative to act on their behalf at any stage during the grievance. If, under applicable law, a person has authority to act on behalf of an Enrollee in making decisions related to health care or is a legal representative of the Enrollee, Molina will treat such person as a personal representative. Providers are permitted to submit a grievance on behalf of the

Enrollee; however, signed consent from the Enrollee is required. Molina will ensure that no punitive action is taken against a Provider who acts as an authorized representative on behalf of the Enrollee or supports a grievance filed by an Enrollee.

When needed, Enrollees are given reasonable assistance in completing forms and taking other procedural steps, including translation services for Enrollees with limited English proficiency or other limitations (e.g., hearing impaired, requiring communication support).

Any grievance or appeal with Potential Quality of Clinical Care (PQCC) is referred to the Quality Improvement (QI) department for documentation and further investigation when appropriate. Additionally, any identified issue related to the privacy and confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

Enrollee grievance timelines

An Enrollee may file a grievance at any time. Grievances may be submitted by phone or in writing. When submitted by phone to the Member Services team, the phone call will serve as the acknowledgment of the grievance. When submitted in writing, a written acknowledgement of the grievance will be sent to the Enrollee within ten (10) business days of receipt. A determination will be made as expeditiously as possible but no later than 60 calendar days from receipt of the grievance. Molina will provide the Enrollee (or designated representative) a notification of outcome.

Reporting

Grievance and appeal trends are reported to the Quality Improvement and Health Equity Transformation Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis, and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement and Health Equity Transformation Committee for evaluation. If required by the state or CMS, reporting is submitted to the appropriate agency as needed.

Record retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of 10 years. In addition to the information documented electronically via the Appeals and Grievances log or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. The Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retain further if the records are under review or audit until the review or audit is complete. The Provider shall request and obtain Molina's prior approval for the disposition of records if agreement is continuous.

15. Credentialing and Recredentialing

The purpose of the Credentialing Program is to ensure that Molina Healthcare and its subsidiaries (Molina) network 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 document, which can be requested by contacting your Molina Provider Relations Manager.

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 was developed in accordance with state and federal requirements and the standards of the NCQA. The Credentialing Program is reviewed annually, and revised and updated as needed.

Nondiscriminatory 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 (e.g., to meet cultural needs of Members).

Types 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.
- Speech and language pathologists.
- Telemedicine practitioners.

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 Provider Network. To remain eligible for participation, practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentation provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude practitioners that 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 that 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 it meets all criteria for initial participation and continued participation in the Molina network. If the practitioner does not 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**—Practitioners must submit to Molina a complete credentialing application either from CAQH ProView or other state-mandated practitioner application. The attestation must be signed within 120 days. The application must include all required attachments.

- **License, certification or registration**—Practitioners must hold a current and valid license, certification, or registration to practice in its 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 where the Member is located.
- **Drug Enforcement Agency (DEA) certificate**—Practitioners must hold a current, valid, unrestricted DEA certificate. Practitioners must have a DEA certificate in every state where the Practitioner provides care to Molina Members. If a practitioner has a pending DEA certificate and never had any disciplinary action taken related to their DEA certificate or chooses not to have a DEA certificate, the practitioner must then provide a documented process that allows another practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.
- **CDS certificate**—Practitioners must hold a current, valid Illinois Controlled Dangerous Substances (CDS) certificate. Practitioners working from Iowa, Indiana, or Missouri practice locations must meet CDS requirements in those states.
- **Specialty**—Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education**—Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency training**—Practitioners must have satisfactorily completed residency training from an accredited program in the specialties in which they are practicing. Molina only recognizes 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**—Fellowship training is verified when a practitioner will be advertised in the directory in their fellowship specialty. Molina only recognizes fellowship programs accredited by ACGME, AOA, CFPC, and CODA.
- **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 residency training from an accredited program in the specialty in which they are practicing. Molina recognizes 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 training from an accredited 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), or as an urgent care, or wound care practitioner. 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**—Practitioners must supply the 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 year, the practitioner must clarify the gap in writing.
- **Malpractice history**—Practitioners 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 an affirmative response to the related disclosure questions on the application exists, a detailed response is required from the practitioner.
- **State sanctions, restrictions on licensure, or limitations on scope of practice** Practitioners must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations, and non-renewals. Practitioners must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If an affirmative response to the related disclosure questions on the application exists, a detailed response is required from the practitioner. 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**—Practitioners 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. Practitioners must disclose all Medicare and Medicaid sanctions. If an affirmative response to the related disclosure questions on the application exists, a detailed response is required from the practitioner. Practitioners 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 an affirmative response to the related disclosure questions on the application exists, 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.
- **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**—Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the practitioner's activities on Molina's behalf. Practitioners maintaining coverage under federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to perform**—Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If an affirmative response to the related disclosure questions on the application exists, a detailed response is required from the practitioner.
- **Lack of present illegal drug use**—Practitioners must disclose if they are currently using any illegal drugs/substances.

[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.

- **Criminal convictions**—Practitioners must disclose if they have ever had any of the following:
  - Criminal convictions, including any convictions, guilty pleas, or adjudicated pretrial diversions for crimes against a person, such as murder, rape, assault, and other similar crimes.
  - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes.
  - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
  - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
  - Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services, or services that fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes.

  At the time of initial credentialing, practitioners must not have any pending criminal charges in the categories listed above.
- **Loss or limitations of clinical privileges**—At initial credentialing, practitioners 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 an affirmative response to the related disclosure questions on the application exists, a detailed response is required from the practitioner. At recredentialing, practitioners 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.
- **National Provider Identifier (NPI)**—Practitioners must have an NPI issued by CMS.

Notification of discrepancies in credentialing information & practitioner's right to correct erroneous information

Molina will notify the practitioner immediately in writing if 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 actions, sanctions, or exclusions. Molina is not required to reveal the source of information if the information is 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 rights are published on the Molina website and 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 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 of Illinois, Inc.
  Attention: Credentialing Director
  22522 29th Drive SE, #L-210
  PO Box 4004
  Bothell, WA 98041

Upon receipt of notification from the practitioner, Molina will document receipt of the information in the practitioner's credentials file. Molina will then reverify 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 the 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 10 calendar days, the 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 rights are published on the Molina website and are included in this Provider Manual.

The Practitioner must notify the Credentialing department and request an appointment 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 that 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 the right, upon request, to be informed of the status of their application by telephone, email, or mail. Practitioner rights are published on the Molina website and are 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.

Professional Review Committee (PRC)

Molina designates a Professional Review Committee (PRC) to make recommendations regarding credentialing decisions using a peer review process. Molina works with the PRC to assure that network Practitioners are competent and qualified to provide continuous quality care to Molina members. The PRC reports to the Quality Improvement Committee (QIC.) Molina utilizes information such as, but not limited to credentialing verifications, Quality of Care (QOC) reviews, and member complaints to determine continued participation in Molina's network or if any adverse actions will be taken. Certain PRC decisions may be appealed. To utilize this process, providers should request a fair hearing as outlined below and in Molina's policy. Please contact Molina Provider Relations representatives for additional information about fair hearings.

Notification of credentialing decisions

Initial credentialing decisions are communicated to practitioners via letter or email. This notification is sent by the Molina Medical Director within two (2) weeks of the decision. Molina will make a credentialing or recredentialing decision within 60 days after submission of all credentials data and completion of verification of the credentials data. Under no circumstance will notification letters be sent to the practitioners later than 60 calendar days from the decision. Notifications of recredentialing approvals are not required.

Recredentialing

Molina recredentials every practitioner at least every 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 that has been convicted of crimes as specified in Section 1128 of the Social Security Act (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 Practitioner sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Practitioners when occurrences of poor quality are identified. If a Molina Practitioner is found to be sanctioned or excluded, the Practitioner'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.
- **The OIG high-risk list**—Monitor for individuals or facilities who refused to enter a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- **State Medicaid exclusions**—Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)**—Monitor for Medicare exclusions through the CMS MED online application site.
- **Medicare preclusion list**—Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database (NPDB)**—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 Practitioner sanctioned by SAM.

Molina also monitors the following for all Practitioner types between the recredentialing cycles.

- Member complaints/grievances.
- Adverse events.
- Medicare opt-out.
- Social Security Administration death master file.

Molina will monitor the timely renewal of health care licenses for all Practitioner types. In the event a Practitioner does not renew their state license prior to the expiration date, Molina may take action, up to and including payment suspension for dates of service on or after license expiration, or termination from applicable Molina Provider Networks.

Provider appeal rights

In cases where the Professional Review Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to laws or regulations.

16. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

- Utilization management.
- Credentialing and recredentialing.
- Claims.
- Complex case management.
- CMS preclusion list monitoring.
- 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) delegated and will be reviewed by Molina's Delegation Oversight staff for compliance with performance expectations within the timeline 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 revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that this is the best course of action.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

17. Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our Members with high-quality, cost-effective drug therapy. Molina works with our Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain Over-the-Counter (OTC) drugs.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T is organized to assist Molina with managing pharmacy resources and to improve the overall satisfaction of Molina Members and Providers. It seeks to ensure Molina Members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee's voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy network

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting CVS Caremark - Pharmacy Locator or calling Molina at **(855) 866-5462**.

Drug formulary

The pharmacy program does not cover all medications. Molina keeps a list of drugs, devices, and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can obtain from a pharmacy. Some medications require Prior Authorization (PA) or have limitations on age, dosage, and/or quantities. For a complete list of covered medications, please visit the Drug List page of the Provider website. You can also visit the Forms page and download the Pharmacy Prior Authorization Form.

Information about procedures to obtain these medications is described within this document and also available on the Drug List page.

Formulary medications

Formulary medications with Prior Authorization may require the use of first-line medications before they are approved. Visit the Forms & Documents page of Molina's Marketplace Provider website to download the Pharmacy Prior Authorization Form.

Quantity limitations

In some cases, Members may only be able to receive certain quantities of medication. Information on limits is included and can be found in the formulary document. Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Step therapy

Plan restrictions for certain formulary drugs may require that other drugs be tried first. The formulary designates drugs that may process under the pharmacy benefit without Prior Authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are **not** considered as meeting step therapy requirements or as justification for exception requests.

Non-formulary medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate or have proven ineffective for a particular Member. Requests for formulary exceptions should be submitted using a Pharmacy Prior Authorization form. Clinical evidence must be provided and is taken into account when evaluating the request to determine Medical Necessity. The use of manufacturer's samples of non-formulary or "Prior Authorization Required" medications does **not** override formulary requirements.

Visit the Forms & Documents page to download the Pharmacy Prior Authorization Form.

Generic substitution

Generic drugs should be dispensed when available. If the use of a particular brand-name, non-preferred drug becomes Medically Necessary as determined by the Provider, Prior Authorization must be obtained through the standard PA process. Visit the Forms & Documents page to download the Pharmacy Prior Authorization Form.

New-to-market drugs

Newly approved drug products will not normally be placed on the formulary during their first six (6) months on the market. During this period, access to these medications will be considered through the Prior Authorization process. Visit the Forms & Documents page to download the Pharmacy Prior Authorization Form.

Medications not covered

Medications not covered by Molina Marketplace are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are **not** part of the benefit. For a complete list of drugs excluded from the plan benefit please refer to the Member's Evidence of Coverage. Visit the Forms & Documents page to download the Pharmacy Prior Authorization Form.

Submitting a Prior Authorization request

Molina's vendor, CVS Caremark, will only process **completed** Prior Authorization request forms; the following information **must** be included for the request form to be considered complete:

- Member first name, last name, date of birth, and Molina Member ID number.
- Prescriber first name, last name, NPI, phone number, and fax number.
- Drug name, strength, quantity, and directions of use.
- Diagnosis.

Molina's decisions are based upon the information included with the Prior Authorization request. Clinical notes are recommended. If clinical information and/or medical justification is missing, Molina will either fax or call your office to request that clinical information be sent in to complete the review. To avoid delays in decisions, complete the Prior Authorization form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Medication Prior Authorization Request form to Molina at **(855) 365-8112**. A blank Pharmacy Prior Authorization Request form may be obtained by accessing MolinaMarketplace.com or by calling **(855) 866-5462**.

Providers and office staff can review Molina Clinical Criteria and Clinical Policies online to ensure all required information is submitted for review

Site of care for administered drugs

For Provider-administered drugs that require Prior Authorization, when coverage criteria are met for the medication, a site-of-care policy is used to determine the Medical Necessity of the requested site of care. Molina covers injectable and infused medications in an outpatient hospital setting or at a hospital-affiliated infusion suite when the level of care is determined to be Medically Necessary. To review the site of care policy, please visit MolinaMarketplace.com.

Molina may conduct Peer-to-Peer discussions or other outreach to evaluate the level of care that is Medically Necessary. If an alternate site of care is suitable, Molina may offer the ordering Provider help in identifying an in-network infusion center, physician office, or home-infusion service, and will help the Member coordinate and transition through Case Management.

Member and Provider "patient safety notifications"

Molina has a process to notify Members and Providers regarding a variety of safety issues, which include voluntary recalls, FDA-required recalls, and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA-accredited organization.

Specialty pharmaceuticals, injectable, and infusion services

Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the Member

or Provider. Some of these same medications may be covered through the medical benefit using Healthcare Common Procedure Coding System (HCPCS) via electronic medical claim submission.

During the Utilization Management review process, Molina will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any federal or state regulatory requirements, and the Member-specific benefit plan coverage prior to determination of benefit processing.

If it is determined to be a Pharmacy benefit, Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes, and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations Manager with any further questions about the program.

Newly FDA-approved medications 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.

"Buy-and-bill" drugs are pharmaceuticals that a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursement.

Molina Clinical Services completes Utilization Management for certain health care administered drugs. Any drugs on the Prior Authorization list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which are later assigned a new HCPCS code, will still require Prior Authorization for such drug even after it has been assigned a new HCPCS code until otherwise noted in the Prior Authorization list.

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, which are 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 that 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 MolinaMarketplace.com under the Health Resource tab. Please consult with your Provider Relations Manager or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

18. Illinois Regulatory Requirements

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

IL-1 Hold Harmless. If the Participating Provider is a hospital, the Participating Provider agrees that in no event, including but not limited to nonpayment by the Payor of amounts due the Participating Provider under the Agreement or this Product Attachment, insolvency of the Payor any breach of the Agreement or this Product Attachment by the Payor, shall the Participating Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Covered Person, persons acting on the Covered Person's behalf (other than the Payor), the employer or group contract holder for Covered Services provided pursuant to the Agreement or this Product Attachment except for the payment of applicable copayments or deductibles for Covered Service or fees for services not covered by the Payor. The requirements of this clause will survive any termination of the Agreement or this Product Attachment for services rendered prior to such termination, regardless of the cause of such termination. The Covered Persons, the persons acting on the Covered Person's behalf (other than the Payor) and the employer or group contract holder will be third party beneficiaries of this Section. This Section supersedes any oral or written agreement now existing or hereafter entered into between the Participating Provider and the Covered Person, persons acting on the Covered Person's behalf (other than the Payor) and the employer or group contract holder. (215 ILL. COMP. STAT. 125/2-8(a); ILL. ADMIN. CODE § 5421.50(e))

IL-2 Quality Assurance. Each Participating Provider (and any of their or its subcontractors) shall provide, arrange for, or participate in the quality assurance programs mandated by the Health Maintenance Organization Act, as may be amended. (215 ILL. COMP. STAT. 125/2-8(b))

IL-3 Examination by the Director. Each Participating Provider agrees that the Director of Public Health may make an examination concerning the quality of health care services provided under the Agreement and this Product Attachment as often as the Director deems it necessary for the protection of the interest of the people of the State, but not less frequently than once every three (3) years. Each Participating Provider shall submit his, hers or its books and records relating to Health Plan and the Payor to examination and in every way facilitate them. Each Participating Provider acknowledges that, for the purpose of examinations, the Director of Insurance and the Director of Public Health may administer oaths to and examine

the principals of the Participating Provider concerning their or its business. (215 ILL. COMP. STAT. 125/5-4)

IL-4 Termination.

IL-4.1 Each Participating Provider shall provide at least sixty (60) days' notice to Health Plan for termination of the Agreement or the termination of its, their participation under this Product Attachment with cause, as may be defined in the Agreement or Provider Manual, and at least ninety (90) days' notice to Health Plan for termination of the Agreement or the termination of its, their participation under this Product Attachment without cause. (ILL. ADMIN. CODE § 5421.50(a)(5))

IL-4.2 Health Plan shall provide at least sixty (60) days' notice to the Participating Provider of the nonrenewal or termination of the Agreement or its, their participation under this Product Attachment. Notwithstanding the foregoing, immediate written notice of non-renewal or termination may be provided by Health Plan without sixty (60) days' notice if the Participating Provider's license has been disciplined by a State licensing board. (215 ILL. COMP. STAT. 134/20)

IL-4.3 Each Participating Provider acknowledges that notification procedures for termination of the Agreement or this Product Attachment are set forth in the Agreement, this Product Attachment, and the Provider Manual. Each Participating Provider agrees that such termination provisions require: (a) not less than thirty (30) days prior written notice by either party who wishes to terminate the Agreement without cause; (b) Health Plan may immediately terminate the Agreement for cause (except as otherwise expressly required by IL-4.1); and (c) if the Participating Provider acts as a primary care physician under a Coverage Agreement requiring a gatekeeper option, the Participating Provider must provide the Payor with a list of all Covered Persons using such Participating Provider as a gatekeeper within five (5) working days after the date that the Participating Provider either gives or receives notice of termination. (ILL. ADMIN. CODE § 2051.290(f))

IL-5 Provider Responsibility. Each Participating Provider acknowledges that the specific Covered Services for which the Participating Provider will be responsible, including any discount services, copayments, benefit maximums, limitations, and exclusions, as well as any discount amount or discounted fee schedule reflecting discounted rates, are set forth in the Agreement (which includes the Provider Manual and all Attachments). (ILL. ADMIN. CODE § 2051.290(a))

IL-6 Administrative Policies. Each Participating Provider shall comply with applicable administrative policies and procedures of Health Plan and the Payor including, but not limited to credentialing or recredentialing requirements, utilization review requirements and referral procedures. (ILL. ADMIN. CODE § 2051.290(b))

IL-7 Records. When payments are due to the Participating Provider for services rendered to a Covered Person, the Participating Provider must maintain and make medical records available: (a) to the Payor for the purpose of determining, on a concurrent or retrospective

basis, the medical necessity and appropriateness of care provided to Covered Persons; (b) to appropriate State and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating member grievances or complaints; and (c) to show compliance with the applicable State and federal laws related to privacy and confidentiality of medical records. (ILL. ADMIN. CODE § 2051.290(c))

IL-8 Licensure. Each Participating Provider shall be licensed by the state, and notify Health Plan immediately whenever there is a change in licensure or certification status. (ILL. ADMIN. CODE § 2051.290(d))

IL-9 Admitting Privileges. If the Participating Provider is a physician, the Participating Provider shall have admitting privileges in at least one hospital with which Health Plan has a written provider contract. Health Plan shall be notified immediately of any changes in privileges at any hospital or admitting facility. Each Participating Provider acknowledges that Health Plan may make reasonable exceptions for a Participating Provider who, because of the type of clinical specialty, or location or type of practice, does not customarily have admitting privileges. (ILL. ADMIN. CODE § 2051.290(e))

IL-10 Continuity of Care.

IL-10-1 Each Participating Provider agrees to accept the responsibilities for continuation of Covered Services in the event of termination of the Agreement, to the extent that an extension of benefits is required by law or regulation, or that continuation is voluntarily provided by the Payor. (ILL. ADMIN. CODE § 2051.290(g))

IL-10-2 Except in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board, each Participating Provider shall continue to provide Covered Services to Covered Persons in an ongoing course of treatment with that Participating Provider for a transitional period following termination or non-renewal of the Agreement or the termination of the Participating Provider's participation under this Product Attachment: (a) for ninety (90) days from the date of the notice to the Covered Person of the termination or non-renewal of the Agreement or the termination of the Participating Provider's participation under this Product Attachment if the Covered Person has an ongoing course of treatment; or (b) if the Covered Person has entered the third trimester of pregnancy at the time of the termination or non-renewal, through delivery and the provision of postpartum care directly related to the delivery. For transitional periods exceeding thirty (30) days, each Participating Provider agrees: (a) to continue to accept reimbursement from the Payor at the rates applicable prior to the start of the transitional period; (b) to adhere to the Payor's quality assurance requirements and to provide to the Payor necessary medical information related to such care; and (c) to otherwise adhere to the Payor's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorization's for treatment. (215 ILL. COMP. STAT. 134/25)

IL-11 Assignment. The rights and responsibilities under the Agreement or this Product Attachment cannot be sold, leased, assigned, assumed, or otherwise delegated by either party without the prior written consent of the other party. By participating under this Product

Attachment, Provider and each Participating Provider is hereby deemed to consent to any assignment or assumption of the Agreement or this Product Attachment by Health Plan, including any assignment or assumption in connection with any purchase of Health Plan by another administrator or insurer. The parties acknowledge that any assignee must comply with all the terms and conditions of the documents being assigned, including all appendices, policies, and fee schedules. (ILL. ADMIN. CODE § 2051.290(h))

IL-12 Insurance. Each Participating Provider has and will maintain adequate professional liability and malpractice coverage, through insurance, self-funding, or other means satisfactory to Health Plan. The Participating Provider shall give Health Plan at least fifteen (15) days advance notice of cancellation of such insurance, and shall notify Health Plan within no less than ten (10) days after the Participating Provider's receipt of notice of any reduction or cancellation of the required coverage. (ILL. ADMIN. CODE §§ 5421.50(a)(7); 2051.290(i))

IL-13 Nondiscrimination. Each Participating Provider shall provide health care services without discrimination against any beneficiary on the basis of participation in a Coverage Agreement, source of payment, age, sex, ethnicity, religion, sexual, health status or disability. (ILL. ADMIN. CODE § 2051.290(j))

IL-14 Financial Responsibility. Each Participating Provider shall collect applicable copayments, coinsurance and/or deductibles (if any) from Covered Persons as provided by the Covered Person's Coverage Agreement, and shall provide notice to Covered Persons of their personal financial obligations for services that are not Covered Services including any amount of applicable discounts or, alternatively, a fee schedule that reflects any discounted rates. (ILL. ADMIN. CODE § 2051.290(k))

IL-15 Availability. Except as otherwise provided in the Provider Manual, each Participating Provider shall provide Covered Services on a twenty-four (24) hour per day, seven (7) day per week basis. (ILL. ADMIN. CODE § 2051.290(l))

IL-16 Payment. Each Participating Provider acknowledges that a clear description of the Payor's payment obligations to the Participating Provider are set forth in the Agreement and this Product Attachment, which includes the Compensation Schedule attached at Exhibit 1. (ILL. ADMIN. CODE § 2051.290(m))

IL-17 Information. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) provides a description of the administrative services, if any, the Health Plan or Payor will perform and the types of information (e.g., financial, enrollment, utilization) that will be submitted to the Participating Provider, as well as other information that is accessible to the Participating Provider. (ILL. ADMIN. CODE § 2051.290(n))

IL-18 Benefit Information. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) identifies the method that

Participating Providers may use to access Health Plan, each Payor, or their designees to obtain benefit information and adequate notice of change in benefits and copayments. Health Plan will arrange for each Payor's operational policies to be accessible to the Participating Provider. (ILL. ADMIN. CODE § 2051.290(o))

IL-19 Dispute Resolution. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) sets forth the applicable internal appeal or arbitration procedures for settling contractual disputes or disagreements between the Participating Provider and the Health Plan. (ILL. ADMIN. CODE § 2051.290(p))

Attestation of Training Completion

The undersigned Organization/Person ("Organization/Person") certifies and attests that as a first-tier entity, downstream entity or related entity (as such terms are defined by Centers for Medicare and Medicaid Services (CMS)), it has obtained and/or conducted required training for it and for all of its personnel and employees, as applicable, (including the Chief Executive, senior administrators or managers, and governing body members), as required for the provision of services under the contracts for the Integrated Care Program, (ICP), Medicare–Medicaid Alignment Initiative (MMAI), and/or Family Health Plan Program (FHP).

Please mark the method(s) of training and education that you or your organization chose to comply with this requirement, as well as the date this training was completed:

	Training Type	**Date Completed**	**Training completed with:** (Health Plan Name)
☐	Abuse, Neglect, Exploitation		
☐	Critical Incidents		
☐	Cultural Competency		
☐	Americans with Disabilities Act (ADA)		
☐	FWA		
☐	Medical Home		

In addition, the Organization/Person certifies and attests that it has required its downstream entities to certify and attest that they have obtained and conducted, as applicable, the required training for all personnel and employees, as applicable. Upon request by the State of Illinois or CMS, the Organization/Person will furnish training logs, as well as certifications or attestations it obtains from its downstream entities to validate that the required training was completed.

Name of Organization/Person	NPI or Tax ID
Name of Organization Representative	Representative Title
Signature	Street Address
Date Signed	City, State, ZIP Code

If more than one individual in your organization completed the training listed above, please complete page 2 of this form.

Attestation of Training Completion

Please list individuals in your organization that have completed the training noted on page 1 of this form:

NPI	Name – Please Print (Last, First)	Position

Please return this form to:

Fax (800) 642-5270

Email IllinoisProviders@MolinaHealthCare.com

Mail Molina Healthcare of Illinois, Inc.
ATTN: Provider Services Department
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Molina Healthcare of Illinois, Inc.
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Phone: (855) 866-5462