



Molina Healthcare Customer Support Center:	In Albuquerque (505) 342-4681 Toll free (800) 580-2811 www.molinahealthcare.com
Integrated Transport Management (ITM) (transportation)	Toll free (888) 593-2052
March Vision Care (MVC):	Toll free (888) 493-4070 TTY/TDD (877) 627-2456
Nurse Advice Line:	Toll free English (888) 275-8750 Spanish (866) 648-3537
New Mexico Relay Services/TTY:	Toll free (800) 659-8331
Health Improvement Hotline	In Albuquerque (505) 342-4660 ext 182618 Toll free (800) 377-9594 ext 182618
Fraud AlertLine:	Toll free (866) 606-3889
Appeals and Grievances:	In Albuquerque (505) 342-4663 Toll free (800) 723-7762
Income Support Division (ISD):	Toll free (800) 283-4465
Your Primary Care Practitioner (PCP):	
Your Durable Medical Equipment (DME) Provider:	

If you have a medical emergency dial 911 or go to the nearest emergency room.

More information can be found on our website at www.molinahealthcare.com

Para recibir esta información en español, llame por favor (505) 342-4681 o (800) 580-2811

Such services are funded in part under contract with the state of New Mexico

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WELCOME

Welcome to Molina Healthcare of New Mexico, Inc. (Molina Healthcare). We are glad you are a Member of the Molina Healthcare family.

Molina Healthcare of New Mexico, Inc. is your Medicaid managed care organization (MCO). Molina Healthcare contracts with the New Mexico Human Services Department (HSD) as a managed care organization for people on Medicaid. A managed care organization contracts with practitioners/ providers. They take care of your medical needs.

This Member Handbook and other Member information are on our website at www.molinahealthcare.com. This Member Handbook has helpful information about Molina Healthcare. The handbook tells you about the benefits and services you can get. It will explain how the Centennial Care Program works. If you have questions about the Centennial Care Program you can call Customer Support Center. We can answer your questions.

Please read your Member Handbook. Your Member Handbook tells you how to use your benefits. It will help you know what your benefits are. Do not wait until you have an emergency. Call us if you have questions. Let us know if you need help understanding your Member Handbook. Keep your Member Handbook where you can find it.

Molina Healthcare wants to help you. Call the Customer Support Center Department if you have questions. You can call us Monday - Friday (except on holidays). Our hours are 8:00 a.m. to 5:00 p.m.

- In Albuquerque: (505) 342-4681
- Toll free: (800) 580-2811
- Fax: (505) 342-0595

Molina Healthcare has Member Service Representatives who speak your language. We can help you with translation services for any language. We can help answer your questions. We can answer questions you have about your Member Handbook. We can answer questions about other member materials you may get.

If you need member materials, such as this Member Handbook, in another format or language, call Customer Support Center. Tell us what you need. If you have special medical needs, please call Customer Support Center. We will help you.

If you are deaf or hard of hearing and you use a TTY system, you can still call Customer Support Center. Molina Healthcare uses the Relay New Mexico service (Relay NM). First dial (800) 659-8331 toll free using the TTY system. A Relay NM operator will come on the line. Give the Relay NM operator Molina Healthcare's toll free telephone number. It is (800) 580-2811. This will connect you with Molina Healthcare's Customer Support Center Department.

Behavioral health care and Long-Term Care services are now offered through Molina Healthcare. If you have questions about your services related to Behavioral Health or Long Term care please call Customer Support Center toll free (800) 580-2811.

QUALITY CARE SERVICES

Molina Healthcare wants to give you high quality care. We work with our practitioners/providers and members to do this. We look at how we can make our services better. We make sure that you:

- Have access to health care services and doctors;
- Are happy with your health care and services;
- Have doctors and hospitals that are qualified to give you quality services;
- Stay healthy by giving you the tools and education you need;
- Get the help you need to get well quickly; and
- Get the tools, education and services to take care of your chronic conditions.

Molina Healthcare is accredited by the National Committee for Quality Assurance (NCQA). NCQA is a group that makes sure we continue to improve the health care and services you get. Molina Healthcare is committed to taking care of you and your family. If you want to know more about Molina Healthcare's

Quality Improvement programs, please call us or visit our website. You can call us in Albuquerque at (505) 342-4660, extension 182618. Or you can call us toll free at (800) 377-9594, ext 182618. You can visit our website at www.molinahealthcare.com.

Thank you for choosing Molina Healthcare. We are happy to help. We are glad you are a Molina Healthcare Member.

Para recibir esta información en español, llame por favor (505) 342-4681 o (800) 580-2811.

INTRODUCTION

CUSTOMER SUPPORT CENTER

What can Customer Support Center do for you?

Customer Support Center can answer your questions. We are here to help you get answers.

You can call or write to Customer Support Center at:

Molina Healthcare of New Mexico, Inc.

Attention: Customer Support Center

P.O. Box 3887

Albuquerque, NM 87190-9859

In Albuquerque: (505) 342-4681 or toll free: (800) 580-2811



Translation and TTY Services

If you speak a language other than English, call Customer Support Center. We can help you if you need help in another language. Customer Support Center will help you with your translation needs.

Para recibir esta información en español, llame por favor
(505) 342-4681 o (800) 580-2811.

If you are deaf or hard of hearing and you use a TTY system, you can still call Customer Support Center. Molina Healthcare uses the Relay New Mexico service. To use this service, first dial toll free (800) 659-8331. Then dial toll free (800) 580-2811.

If you need your member materials in another format, call Customer Support Center. Tell us what you need.

If You Move

If you move, you must update your address. You must contact your local Income Support Division (ISD) office or HSD. They will help you change your records. Please call Customer Support Center to update your address as well.

New Medical Equipment and Treatments

Molina Healthcare wants to make sure that our members get the best care. On a regular basis we look at procedures and technology

relating to health care. When we learn about something new, we take this information into consideration.

We try to make sure it is the best thing for our members. A committee of practitioners reviews and tells us about new treatments. Molina Healthcare then decides if it is a service our members can get. If you want to know how Molina Healthcare makes these decisions, call Customer Support Center.

Handicapped Access

Molina Healthcare practitioners must have handicapped access for members. If you have another special need, please call Customer Support Center.



Filing a Claim

It is the practitioner's/provider's job to file a claim when you get services. They must do this when Molina Healthcare is the primary insurance. They must send the claim within ninety (90) days from the date you get the service. You must pay your co-payment if one applies. You do not have to pay for the services if you get a referral when needed. You do not have to pay for the services if your practitioner/provider gets a prior authorization when needed. You do not need to file a claim to Molina Healthcare. This is the practitioner's/ provider's job.

Coordination of Benefits

Please call Customer Support Center to tell us if you:

- Have medical insurance through your workplace;
- Have been hurt at work or have a worker's injury claim;
- Are in a car accident;
- Have filed a medical malpractice lawsuit or personal injury claim; or
- Have other coverage or insurance.

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights (Patient Bill of Rights)

1. Members or their legal guardians have a right to get information about Molina Healthcare, its policies and procedures about products, services, contracted practitioners/providers, grievance procedures, benefits provided and Members' rights and responsibilities.
2. Members have a right to be treated with courtesy and kindness, and with respect and recognition of their dignity, need and right for privacy.
3. Members or their legal guardians have a right to choose a PCP within the limits of the covered benefits and plan network, and the right to refuse care of specific practitioners or to notify the provider if changes need to be requested.
4. Members or their legal guardians have a right to get from the member's practitioner(s), in terms that the member or legal guardian(s) understands, an explanation of their complete medical condition, and recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, regardless of the health care insurer's or Molina Healthcare's position on treatment options. If the member is not able to understand the information, the explanation shall be provided to their next of kin, guardian, agent or surrogate, if available, and noted in the member's medical record.
5. Members have a right to get health care services in a non-discriminatory fashion.
6. Members who do not speak English as their first language have the right to get translation services at no cost for communication with Molina Healthcare.
7. Members who have a disability have the right to get information in an alternative format in compliance with the Americans with Disabilities Act.
8. Members or their legal guardians have a right to participate with their health care practitioners/providers in decision making in all aspects of their health care, including the treatment plan development, acceptable treatments and the right to refuse treatment.
9. Members or their legal guardians shall have the right to informed consent.

10. Members or their legal guardians shall have the right to choose a surrogate decision-maker to be involved as appropriate and to help with care decisions.
11. Members or their legal guardians shall have the right to get a second opinion by another practitioner/provider in the Molina Healthcare network when members need more information about recommended treatment or believe the practitioner/provider is not authorizing the care requested.
12. Members have a right to an open and honest discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
13. Members or their legal guardians have a right to voice complaints, grievances or appeals about Molina Healthcare, the handling of complaints, or the care provided and make use of Molina Healthcare's complaint process and the State's Fair Hearing process after exhausting Molina Healthcare's Grievance/Appeal process, at no cost, without fear of retaliation.
14. Members or their legal guardians have a right to file a complaint or appeal with Molina Healthcare or the State's Hearing Bureau after exhausting Molina Healthcare's Grievance/Appeal process for Medicaid members, and to get an answer to those complaints or appeals within a reasonable time.
15. Members or their legal guardians have a right to choose from among the available practitioners/providers within the limits of Molina Healthcare's network and its referral and prior authorization requirements.
16. Members or their legal guardians have a right to make their decisions known through advance directives about health care decisions (i.e., living wills, right to die directives, "do not resuscitate" orders, etc.) consistent with federal and state laws and regulations.
17. Members or their legal guardians have a right to the privacy of medical and financial records kept by Molina Healthcare and its practitioners/ providers, in accordance with existing law.
18. Members or their legal guardians have a right to access the member's medical records in accordance with the applicable federal and state laws and regulations.

19. Members have the opportunity to allow or deny the release of identifiable medical or other information by Molina Healthcare, except when such release is required by law.
20. Members have a right to ask for an amendment to their Protected Health Information (PHI) if the information is believed to be incomplete or wrong.
21. Members or their legal guardians have a right to get information about Molina Healthcare, its health care services, how to get those services and the network practitioners/providers.
22. Members or their legal guardians have a right to be given information about Molina Healthcare's policies and procedures regarding products, services, practitioners/providers, appeal procedures, allowing use of member medical information, allowing members access to their medical records, and protecting access to member medical information and other information about Molina Healthcare and the benefits provided.
23. Members or their legal guardians have a right to know, upon request, of financial arrangements or provisions between Molina Healthcare and its practitioners/providers, which may limit referral or treatment options or limit the services offered to the members.
24. Members or their legal guardians have a right to be free from harassment by Molina Healthcare or its network practitioners/providers concerning contractual disputes between Molina Healthcare and practitioners/providers.
25. Members or their legal guardians have a right to available and accessible services when medically necessary as determined by the PCP or treating practitioner/provider in consultation with Molina Healthcare, twenty-four (24) hours per day, seven (7) days per week for urgent or emergency care services and for other health care services as defined by the contract or evidence of coverage.
26. Members have a right to adequate access to qualified health professionals near where the member lives or works, within the service area of Molina Healthcare.

27. Members have a right to affordable health care, with limits on out-of-pocket expenses, including the right to get care from a non-participating practitioner/provider and an explanation of a member's financial responsibility when services are given by a non-participating practitioner/ provider, or given without required pre-authorization.
28. Members or their legal guardians have a right to prompt notification of termination or changes in benefits, services or provider network.
29. Members have a right to get care from a non-participating practitioner/ provider and to be told of their financial responsibility if they get services from a non-participating practitioner/provider, or get services without required prior authorization.
30. Members have the right to continue an ongoing course of treatment for a period of at least thirty (30) days. This shall apply if the member's practitioner/provider leaves the provider network, or if a new member's practitioner/provider is not in the provider network.
31. Members have the right to make recommendations about the organization's Member rights and responsibilities policies.
32. Members have a right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
33. Members or their legal guardians shall have the right to select an MCO and exercise switch enrollment rights without threats or harassment.
34. Members have a right to detailed information about coverage, maximum benefits and exclusions of specific conditions, ailments or disorders, including restricted benefits and all requirements that a member must follow for prior approval and utilization review.
35. Members or their legal guardians have all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands.

36. Members or their legal guardians have the right to a complete explanation of why care is denied, an opportunity to appeal the decision to Molina Healthcare's internal review, the right to a secondary appeal, and the right to ask for the HSD's help as applicable.
37. Members or their legal guardians have the right to get information, when they ask, that HSD determines is important during the member's first contact with the MCO. This information can include a request for information about the MCO's structure, operation and/or practitioners or senior staff's incentive plans.
38. Members or their legal guardian shall be free to exercise his/her rights and exercising those rights will not result in adverse treatment of the member or their legal guardian.

Member Responsibilities

1. Members or their legal guardians have a responsibility to give, to the extent possible, information that Molina Healthcare and its practitioners/ providers need in order to care for him/her.
2. Members or their legal guardians have a responsibility to understand the member's health problems and to help in developing treatment goals that everyone can agree to.
3. Members or their legal guardians have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioner/ provider or to notify providers if changes are requested.
4. Members or their legal guardians have a responsibility to keep, reschedule or cancel an appointment rather than to simply not show-up.
5. Members or their legal guardians have a responsibility to look at their Member Handbook and if there are questions call the Customer Support Center Department for clarification of benefits, limitations and exclusions. The Customer Support Center telephone number is located on the member's identification card.
6. Members or their legal guardians have a responsibility to follow Molina Healthcare's policies, procedures and instructions for getting services and care.

7. Member or legal guardians who self-refer to a specialist or provider without following Molina Healthcare procedures, and Molina Healthcare denies the service, the provider may bill the member.
8. Members or their legal guardians have a responsibility to show their member identification card each time they go for medical care and to tell Molina Healthcare right away of any loss or theft of their identification card.
9. Members or their legal guardians have a responsibility to tell a participating practitioner/provider of their coverage with Molina Healthcare at the time of service. Members may have to pay for services if they do not tell the participating practitioner/provider of their coverage.
10. Members or their legal guardians have a responsibility to pay for all services they get before the effective date with Molina Healthcare and after the termination or cancellation of coverage with Molina Healthcare, if they did not have insurance. Members that are covered with Fee-for-Service Medicaid, another MCO or by another insurance company before the effective date or after termination or cancellation with Molina Healthcare should tell the practitioner/provider about their other coverage.
11. Members or their legal guardians have a responsibility to tell their ISD Caseworker if there is a change in name, address, telephone number or changes in their family.
12. Members or their legal guardians have a responsibility to tell HSD and Molina Healthcare if they get other medical coverage.
13. Members or their legal guardians have a responsibility to pay for all required co-payments and/or coinsurance at the time services are rendered.

Your Rights about Advance Directives

Medical Care gives adults the right to make choices about their medical care in case of terminal illness or emergency. This means you can get medical care or choose not to get medical care. The choice you make for any limitations about the use of advance directives is a matter of conscience.

Your practitioner will have Advance Directive forms in his/her office. You can fill out the form. The form will tell your family, practitioners and those who need to know how you want to be cared for during an illness or medical emergency.

The form will tell how you want to be cared for even when you can no longer speak for yourself. After you complete the form, it will be put in your medical file. You can end or change the advance directive at any time. You just need to communicate your wish to do so. If you want to know more about this, call Customer Support Center. We will help you.



Behavioral Health Advanced Directives:

You have the right to create an Advanced Mental Health Care Directive (AMHCD) for your mental health and substance issues. This Directive is a written document that tells your health care providers, family members and others what your wishes are if you go into relapse for your behavioral health issues or are not able to make decisions for yourself about your care. Your AMHCD should be written, signed, and witnessed.

Your Advanced Mental Health Care Directive should include:

- A designated person (“agent”) to make decisions for you if you are too sick or ill to make decisions for yourself. This is called being “incapacitated”.
- A written set of instructions on what you would like to have happen and how or where you would like to be treated if you cannot make decisions for yourself. This could include:
- Medications that you do not want given or would prefer be given
- Places you would like to be taken for treatment or types of treatment
- Treatment you should or should not be given
- People who may or may not visit you in treatment
- Your Molina Care Coordinator and Providers will have Behavioral Health Advanced Directive Forms and can assist you in filling them out.

PRIMARY CARE PRACTITIONER (PCP)

One of the most important steps in taking care of your health is establishing a health home. When you choose a Primary Care Practitioner (PCP), you are choosing a health home. Your PCP is the provider who will help you with most of your medical

needs. Your PCP will give you care, offer advice, and refer you to a specialist when necessary. Your PCP will be sure you receive the specialist and hospital care you need. When you pick a PCP who meets your needs and whom you are comfortable with, you can develop a lasting relationship that will help to ensure a health care partnership for years to come.

Choosing a PCP

Each member of Molina Healthcare must choose a PCP from Molina Healthcare's provider directory. PCPs contracted with Molina Healthcare are listed in the provider directory. You can also access the provider directory online at www.MolinaHealthcare.com. If member is a current Molina Healthcare Member you can keep your current PCP as they are a Molina provider. You can choose a PCP from the following:

- General/Family practitioner: a practitioner for people of all ages;
- Pediatrician: a practitioner for infants, children and teenagers;
- Internal Medicine: a practitioner for adults and sometimes teenagers; or
- OB/GYN: a practitioner who treats women for pregnancy and female health issues
- In certain cases, a specialist can be assigned as your PCP.

Your PCP can be a Medical Doctor (MD), Doctor of Osteopathy (DO), Certified Nurse Practitioner(CNP), or Physician Assistant (PA). A Molina Customer Service Representative can assist you in selecting a PCP if you call 1-800-580-2811. If you would like to receive a paper copy of the Provider Directory please call Member Services Native American members may self-refer to an Indian Health Service/Tribal 638/Urban Indian Providers (I/T/U) for services.

To choose a PCP:

- You can choose a PCP online. Go to Molina Healthcare's website at www.molinahealthcare.com;
- If you would like help with choosing a PCP, you can contact Customer Support Center at (505) 342-4681 or (800) 580-2811 (TTY for the hearing impaired: 1-800-947-3529); or

- After you have selected a PCP from the provider directory, you can fill out the PCP Selection Form that is included in your member packet. Mail it in the envelope provided. You will not need a stamp.

Once you have a PCP, you should schedule a checkup soon, even if you are not sick. During the appointment, you will have a chance to get to know your PCP and to ask a number of questions that will help you develop a good relationship.



Your PCP will:

- See you for routine checkups;
- See you when you are sick or injured;
- Tell you when you need to see a specialist; and

You can reach your PCP by calling the PCP's office. If you would like to know more about your PCP or other Molina Healthcare providers, call Customer Support Center. You can get information about your provider's professional qualifications, such as medical school attended, residency completed, and board certification status. You can also get information on the languages your provider speaks.

Remember to call your PCP for advice before you get care anywhere else. Call 911 for medical emergencies. Call Customer Support Center if you have questions. Let us know if you need help with appointments.

Molina Healthcare's 24-Hour Nurse Advice Line

Nurses can help you by telephone. You can reach them twenty-four (24) hours a day, seven (7) days a week. You can reach them on holidays. They can help you with health questions. They can tell you what medical care you may need. If you cannot reach your PCP or talk with the practitioner/provider on-call, you can call Molina Healthcare's 24-Hour Nurse Advice Line. Call them toll free at (888) 275-8750 for an English-speaking representative. Or you can call toll free (866) 648-3537 for a Spanish-speaking representative.

Member Identification (ID) Card

After you pick your PCP, Molina Healthcare will send you an identification (ID) card. The ID card will have your name and ID number on it. It will also have your PCP's name, address and telephone number. If the information on your card is wrong or if your card was lost or stolen, call Customer Support Center. We will send you a new ID card.

All family members will have their own ID card. Only the person on the ID card can use it for services. If you think someone has used your ID card, please call Customer Support Center or HSD.

Carry your ID card with you when you go to see your PCP. Carry your ID card with you when you get a prescription filled. This card has important information about Molina Healthcare. You should also carry your blue Medicaid card sent to you by HSD. After you get your ID card, call your PCP for an appointment.

Your PCP will:

- See you for routine checkups;
- See you when you are sick or injured;
- Tell you when you need to see a specialist; and
- Arrange for care at night, on the weekend or during a holiday.

If you need care before you get your ID card, please call Customer Support Center.

Choosing a Specialist as a PCP

If you have a serious illness and are seeing a specialist, your specialist may be able to act as your PCP. The specialist must agree to meet the minimum requirements of Molina Healthcare's PCP care. Call Customer Support Center to ask about this.

Members may be approved to have a specialist act as their PCP. These decisions are based on continuity of care. They must be approved by Molina Healthcare's Medical Director. The member must get a written note from the specialist whom they want as a PCP. The specialist must agree to act as a PCP for that member. The note must include the reason for using the specialist as a PCP. The specialist must send the note to



Molina Healthcare's Healthcare Services department at:

Molina Healthcare of New Mexico, Inc.

ATTN: Healthcare Services

P.O. Box 3887

Albuquerque, NM 87190-9859

The specialist can fax the note toll free to (888) 802-5711.

The request will be denied if the specialist does not want to be your PCP. The request will be denied if the note does not show why the specialist must be your PCP. You and the specialist will be notified of the denial by telephone. This call will happen within twenty-four (24) hours of the denial decision. You and the specialist will also be notified in writing. You will get this notice within two (2) working days after the denial decision. You will also be told of your appeal rights. You will be told of your right to select a different PCP.

If Your PCP leaves the Network

If your PCP leaves the Molina Healthcare network, we will send you a letter telling you about this right away. We will pick a new PCP for you and we will send you a new ID card. You can keep this PCP. You can also call Customer Support Center to pick a PCP of your choice from the Molina Healthcare network.

If the PCP is outside of the Molina Healthcare network, please call Customer Support Center. They will tell you if you can still see that PCP. If you see a PCP outside the Molina Healthcare network, you may have to pay the bill.

How to Get Information about Providers

Call Customer Support Center if you have any questions about your PCP. Call Customer Support Center if you have questions about providers that are contracted with Molina Healthcare.

Health Homes

In addition to traditional PCPs, you can choose to obtain your primary services through

- Patient Centered Medical Homes
- ECHO Intensivist Clinics
- Health Home through Core Service Agencies

If you would like more information about these options, please call our Support Services Center:

In Albuquerque (505) 342-4681

Toll-free (800) 580-2811

BENEFITS AND SERVICES

BASIC BENEFITS AND SERVICES

Some of the services that Centennial Care covers:

- PCP services (In-Plan);
- Well-Child health check-ups;
- Behavioral Health;
- Family planning;
- Home health services;
- Durable Medical Equipment (DME);
- Dental services through Denta Quest;
- Vision services through March Vision
- Emergency ambulance rides;
- Emergency services;
- Some types of non-emergency transportation ; and
- Long-Term nursing services.



Services you can get without a referral from your PCP

You may get vision, dental, family planning, OB/GYN and behavioral health services without seeing your PCP. You can get these services without getting a referral. You can get these services by calling:

- Routine Vision – Call March Vision Care (MVC) toll free at (888) 493-4070;
- Routine Dental – Call Molina Healthcare toll free at (800) 341-8478;
- OB/GYN – Women can self-refer for family planning services;
- Behavioral Health Services – Call Customer Support Center toll free at (800) 580-2811;
- Emergency Services – Dial 911 or go to the nearest emergency room. A prior authorization (approval) is not needed.

Family Planning Services

Members can get family planning services in or out-of-network. They can do this without asking their PCP. This includes adolescents. Female members have the right to refer themselves to

a Women's Health specialist for routine and preventive women's health services. The specialist may be in or out of the Molina Healthcare network.

Examples of services covered under family planning are:

- Tests to help with choice of birth control; and
- Follow-up care for problems with birth control.

For more information about family planning services, call Customer Support Center.

Long Term Care (LTC) Services

Long Term Care services benefit people with chronic physical and/ or mental health disorders. When you complete a Health Risk Assessment with Molina, the results of that HRA will indicate if you may benefit from Long-Term Care Services, if you are not already receiving these services. An in-home Comprehensive Needs Assessment will help you and your Care Coordinator determine what types of LTC services may benefit you. In order to receive some services in the LTC package, you will need an order from your PCP. These services include Nursing Home admission, Assisted Living, Home Health Aide, Private Duty Nursing, Occupational Therapy, Physical Therapy and Speech Therapy. Your Care Coordinator will work with your PCP to obtain this order if your PCP agrees the services are needed.

Nursing Home Services

If you require 24 hour care and meet criteria to enter a nursing home, you may choose to go into a nursing home. If you do need 24 hour care, you can use the Community Benefit to supplement the care you receive from your natural supports.

Community Benefits

If you do not require 24 hour care, you may choose to remain in your home and receive Community Benefit services in your home. Community Benefits do not provide 24 hour care. If you do need 24 hour care, you can use the Community Benefit to supplement the care

you receive from your natural supports. The Community Benefits offers you the opportunity to remain in the community and receive the services you need to meet your health and safety needs.

Self-Directed Community Benefit (SDCB)

You choose which Self Directed Community Benefit services are provided, who provides the services and how much providers are paid. Before you can go into the SDCB, you must be in the Agency Based Community Benefit for a minimum of 120 days. This allows you to receive services while you are setting up your SDCB care plan. The plan you set up is reviewed by Molina to ensure it meets your health and safety needs. Part of the review includes the information in your Health Risk Assessment (HRA) and Comprehensive Needs Assessment (CNA.) The HRA and CNA are completed with information you provide to Molina.

Agency Based Community Benefit	Self Directed Community Benefit
Adult Day Health	Not included
Assisted Living	Not included
Behavior Support Consultation	Behavior Support Consultation
Community Transition Services	Not included
Not included	Customized Community Supports
Emergency Response System	Emergency Response System
Employment Supports	Employment Supports
Environmental Modifications	Environmental Modifications
Home Health Aide	Home Health Aide
Not included	Homemaker
Not included	Nutritional Counseling
Personal Care Services	Not included
Private Duty Nursing (21 years of age & older)	Private Duty Nursing (21 years of age & older)
Not included	Related Goods
Respite (100 hours per year)	Respite (100 hours per year)

Skilled Maintenance Therapies (Occupational, Physical and/or Speech Therapy for Members age 21 and older)	Skilled Maintenance Therapies (Occupational, Physical and/or Speech Therapy for Members age 21 and older)
Not included	Specialized Therapies
Not included	Transportation (non-medical)

Services for Native American Members

Native American members can self-refer to Indian Health Services (IHS) or 638 Tribal Healthcare facilities. This can be done for any service. They do not need to ask their PCP for permission. Native American Members can also self-refer to any provider on the Molina Healthcare network. Members that are registered as Native American members with the Income Support Division (ISD) do not have copayments for any services.

Native American members can access a traditional medicine benefit once a year as part of their health care. For more information, call Customer Support Center. To get a copy of the Traditional Medicine application, call Customer Support Center.

Summary of Most Common Services and Co-payments

Summary of Benefits Centennial Care, CHIPRA (Children's Health Insurance Program Reauthorization Act) and WDI (Working Disabled Individuals)			
Service	Centennial Care	CHIPRA	WDI
Physician/ Practitioner Visits	\$0	\$5	\$7
Pre/Post Natal Care	\$0	\$0	\$0
Preventive Services	\$0	\$0	\$0
Hospital Inpatient	\$0/per	\$25/per	\$30/per
Medical/Surgical	admission	admission	admission
Hospital Inpatient	\$0/per	\$25/per	\$30/per
Maternity	admission	admission	admission
Hospital Outpatient	\$0	\$5	\$7
Medical/Surgical			
Home Health	\$0	\$5	\$7

Physical, Occupational and/or Speech Therapy	\$0	\$5	\$7
Diagnostic Services (excluding routine lab and x-ray)	\$0 included in office visit	\$0 included in office visit	\$0 included in office visit
Durable Medical Equipment (DME)/ Supplies	\$0	\$0	\$0
Emergency Services	\$0	\$15/per visit, waived if admitted to a hospital within 24 hours	\$20/per visit, waived if admitted to a hospital within 24 hours
Urgent Care	\$0	\$5	\$7
Prescription Medication: Generic/Brand	\$0/per prescription	\$2/per prescription	\$5/per prescription
Behavioral Health and Substance Abuse	Molina Healthcare now handles your Behavioral Health and Substance Abuse Benefits. Please call Customer Support Center toll free at (800) 580-2811.		
Transportation	Transportation services are offered by Integrated Transport Management (ITM). Please call ITM toll free at (888) 593-2052.		
Vision	Routine vision services are offered by March Vision Care (MVC). Please call MVC toll free at (888) 493-4070.		
Dental	Routine dental services are offered by DentaQuest. Please call Molina Healthcare Customer Support Center toll free at (800) 580-2811.		

More information on co-payments and other costs you must pay:

- Co-payments do not apply to Native Americans, children or Native
- American Working Disabled Individuals.
- Providers cannot bill you for services except for certain copayments for:
 - Services you receive in an Emergency Department for a non-emergency. If your earned income and unearned income is more than 100% of the Federal Poverty Level, you may owe a copayment. You will not be denied services if you cannot pay the copayment.
 - Prescriptions when an equal, generic drug is available. This does not apply to “psychotropic drugs.” If your earned and unearned income is more than 100% of the Federal Poverty Level, you may owe a copayment. You will not be denied services if you cannot pay the copayment.
- Members living in a residential facility must pay their share. Molina can help you with questions about this.
- Providers may use legal actions to collect these copayment amounts.

All benefits are subject to plan limitations and plan prior authorization requirements.

Standard Covered Services

Some services may need a prior authorization (approval). Call Customer Support Center to find out which services need a prior authorization. Do this before you get the service.

- Primary Care Practitioner (PCP) services: office visits, home visits, routine care, physical exam, office procedures and shots;
- Routine and diagnostic X-rays and clinical laboratory tests, routine electrocardiograms (EKGs) and electroencephalograms (EEGs);
- Inpatient and outpatient surgery;
- Inpatient professional care services including pathologists, radiologists and anesthesiologists;
- Inpatient hospital services - These services need prior authorization. They also need your PCP’s referral. These services include:

- Semi-private room and board accommodations, including general duty nursing care;
- Private room and board accommodations when medically necessary;
- In-hospital therapeutic and support care, services supplies, and appliances, including care in specialized intensive and coronary care units;
- Use of all hospital facilities, including operating, delivery, recovery and treatment rooms and equipment;
- Laboratory tests, x-rays, electrocardiograms (EKGs), electroencephalograms (EEGs) and other diagnostic tests done in combination with a member's admission to a hospital;
- Anesthetics, oxygen, medications and other biologicals;
- Dressings, casts and special equipment when given by the hospital for use in the hospital;
- Inpatient meals and special diets;
- Inpatient radiation therapy and/or inhalation therapy;
- Rehabilitative services – physical, occupational and speech therapy;
- Administration of whole blood, blood plasma and components; and
- Discharge planning and coordination of services.
- Maternity Care;
- Outpatient hospital services that can reasonably be given on an outpatient basis;
- Surgeries, including use of operating, delivery, recovery and treatment rooms, equipment and supplies including anesthesia, dressings and medications;
- MRI, CT Scans and Positron Emission Tomography (PET) tests;
- Radiation therapy and chemotherapy;
- Holter monitors and cardiac event monitors;
- Rehabilitative services – including heart and short-term, physical, occupational and speech therapies;
- Emergency and post stabilization care - including twenty-four (24) hour emergency medical care and emergency room service;
- Same day care or urgent care and urgently needed health services;



- Women's health services;
- Mammography and cytological screening;
- Services related to the diagnosis, treatment and appropriate management of osteoporosis;
- Prenatal and post-partum care;
- Non-hospital births;
- Preventive health services including physical exams and periodic tests;
- Family planning services (including birth control pills, supplies and devices, surgical procedures to cause sterility or prevent pregnancy);
- Dialysis services;
- Inpatient physical rehabilitation services;
- Home health services;
- Ambulance service (emergencies only);
- Limited oral surgery;
- Limited reconstructive surgery;
- Prescription Medication;
- Diabetes treatment services; equipment, supplies and appliances to treat diabetes. Benefits include:
 - Blood glucose monitors, including those for the legally blind;
 - Test strips for blood glucose monitors;
 - Visual reading urine and ketone strips;
 - Lancets and lancet devices;
 - Insulin (limit two [2] vials per co-payment);
 - Injection aids, including those adaptable to meet the needs of the legally blind;
 - Syringes;
 - Prescriptive oral agents for controlling blood sugar levels; and
 - Medically necessary podiatric appliances to help prevent foot complications related to diabetes. This includes therapeutic molded or depth inlay shoes, functional orthotic appliances, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and Glucagon emergency kits.
- Durable Medical Equipment (DME) (wheelchairs, walkers, oxygen, etc.) (See Limitations);

- Prosthetics and Orthotics (See Limitations);
- Organ Transplants; and
- Health Education.

*These services may require prior authorization. Your provider will obtain the prior authorization if needed.

How to Get a Second Opinion

A second opinion is when you ask to see another Molina Healthcare practitioner/provider about your medical condition. You can get a second opinion from another practitioner/provider. If a qualified practitioner/provider is not available in the network at no cost to the member, you have the right to get a second opinion. You can get a second opinion from a qualified practitioner/provider outside of the network. If you think you need a second opinion, call Customer Support Center.

How to Get Hospice Care

Hospice is a service to care for a patient with a terminal illness. The patient usually has a life expectancy of six (6) months or less. Licensed hospice programs in the state of New Mexico give support and comfort to the patient and the family during the final months of life. Hospice services offer palliative care, which gives relief from pain and other symptoms, rather than curative treatment. The goal of hospice is to make sure that a patient's remaining time is as pain-free and peaceful as possible.

Hospice care improves the quality of life for the patient. It gives a personalized plan of care that focuses on the patient's comfort and dignity. Hospice staff respects the wishes of the patient. They encourage communication among family members and the medical team.

Members who have a terminal illness can get hospice care. If you have questions about hospice care, call Customer Support Center.

BEHAVIORAL HEALTH SERVICES

Behavioral health care services are now provided through Molina Healthcare of New Mexico. If you have questions about your behavioral health needs, call. If you need to talk to someone, call. If you need help with your Behavioral referral, call Molina Customer Support Center.

Call Customer Support Center if you have questions about covered or non-covered services. We will answer your questions.

Contacting a Peer Support Specialist for Behavioral Health Needs:

Molina Healthcare supports the use of Peer and Family Support Specialists to assist members in their recovery from mental health or substance abuse issues. Please call your care coordinator at Molina for referral to a program which provides peer support specialists or for referral to a wellness centers. You may also call your local Core Service Agency in your community for support in connecting to a peer support specialist or local wellness center.

The Table below shows the covered Behavioral Health Services you can receive. Some services require prior authorization by a Molina Care Coordinator. If a service requires prior authorization, your Behavioral Health Provider will call the Molina Care Review Clinician to get approval for your care.

Adult Behavioral Health Services	Child and Adolescent Behavioral Health Services
Inpatient and Residential Treatment Services: <ul style="list-style-type: none">• Inpatient Psychiatric Hospital Care• 23 Hour Observation in a Hospital or Emergency Room• Partial Hospitalization• Psychiatric Emergency Services (PES) provided at the University of New Mexico	Inpatient, Residential Treatment, and Out of Home Services: <ul style="list-style-type: none">• Inpatient Psychiatric Hospital Care• 23 Hour Observation in a Hospital or Emergency Room• Days Waiting Placement• Residential Treatment Services in Accredited and State Licensed RTCs• Group Home• Treatment Foster Care, Levels I & II (under 21 years of age)

*These services require prior authorization. The facility will obtain the prior authorization.

<p>Outpatient Services:</p> <ul style="list-style-type: none"> • Individual, Family & Group Outpatient Counseling and Psychotherapy • Outpatient Medication Management • Outpatient Psychological Testing • Intensive Outpatient Programs (IOP) • Assertive Community Treatment (ACT) (ages 18 and up) • Psychosocial Rehabilitation (PSR) Program • Comprehensive Community Support Services • Comprehensive Assessment at a Core Service Agency • Telehealth Services • Respite Services • Recovery Services • Family Support Services 	<p>Outpatient Services:</p> <ul style="list-style-type: none"> • Individual, Family & Group Outpatient Counseling and Psychotherapy • Outpatient Medication Management • Outpatient Psychological Testing • Intensive Outpatient Programs (IOP) (ages 13 & up) • Comprehensive Community Support Services • Comprehensive Assessment at a Core Service Agency • Day Treatment (under 21 years of age) • Multi-Systemic Therapy (MST) (ages 10-18) • Behavior Management Services (BMS) (under 21 years of age) • Adaptive Skills Building (under 5 years of age) for Autism • School Based Services (Not IEP services) • Telehealth Services • Respite Services • Recovery Services • Family Support Services
<p>Specialty Substance Abuse Services:</p> <ul style="list-style-type: none"> • Medication Assisted Treatment (MAT) at a Methadone Clinic (ages 18 and up) • Suboxone Treatment (ages 16 and up) 	<p>Specialty Substance Abuse Services:</p> <ul style="list-style-type: none"> • Medication Assisted Treatment (MAT) at a Methadone Clinic (Some Methadone providers will accept members ages 16 to 18 dependent on need and physician approval for admission) • Suboxone Treatment (ages 16 and up)

*These services require prior authorization. Your provider will obtain the prior authorization.

Molina Healthcare also provides value added services for Behavioral Health care outside of the covered benefit package. These services must be arranged by a Molina Care Coordinator and have benefits limitations.

Adult Behavioral Health Value Added Services	Child and Adolescent Behavioral Health Value Added Services
<ul style="list-style-type: none"> • Transitional Living Services (age 21 and up) • Milagro Program for Expectant Mothers with substance abuse 	<ul style="list-style-type: none"> • Transitional Living Services (ages 16-21) • Infant Mental Health

*These services require prior authorization. Your provider will obtain the prior authorization.

ADDITIONAL BENEFITS AND SERVICES

How to Get Dental Care

Taking care of your teeth can help keep you healthy. Molina Healthcare works with DentaQuest. They will take care of your dental needs. If you are pregnant, dental care is very important to your health and your baby’s health. Good dental care may help prevent premature birth.

You may have dental coverage for the following care when it is medically necessary:

- Preventive dental care, such as cleanings and x-rays. These services help to keep your teeth healthy;
- Restorative care, such as fillings, root canals and crowns. These services help to fix dental problems you may have;
- Prosthetics such as bridges and dentures. These services help to replace lost teeth;
- Periodontia is a service to take care of your gums; and
- Orthodontia (braces). Braces are covered when teeth are so crooked that they cause medical problems. They are not covered for cosmetic purposes. (A member must reach a score of thirty (30) points on the Handicapping LabioLingual Deviations (HDL) scoring tool to qualify for braces.)



How to Get Vision Care

Regular eye exams are important. These exams allow your March Vision Care (MVC) doctor to find and treat eye problems before they start. This can happen even before you notice any problems. Follow these simple steps when you are ready to use your MVC benefit:

1. Find a MVC doctor
 - Call a MVC representative toll free at (888) 493-4070. Or TTY/TDD (for the hearing impaired) toll free at (877) 627-2456;
 - Find a MVC doctor by using your MVC provider directory; or
 - Visit the MVC website at www.marchvisioncare.com.
2. Call a MVC doctor
 - Make an appointment;
 - Tell the doctor you are a MVC member;
 - Give your identification number to the doctor (this number is on your member identification card); and
 - Your MVC doctor will check with MVC to see if you can get services. If you cannot get services, your MVC doctor will let you know.
3. After your Eye Exam
 - Your MVC doctor will discuss your eyewear and/or treatment options with you.

If you have diabetes, you should have an annual dilated eye exam. This is not the same as an eye exam for glasses.

MEDICAID BIRTHING OPTIONS PROGRAM

If you are pregnant and eligible for Medicaid, you have a choice of who will provide care for you. You can also choose where your baby will be born. Women in New Mexico have choices about where to give birth:

- A birth center;
- A hospital; or
- Your own home.

Many health care practitioners/providers offer pregnancy-related services. Many times they work together to provide care for you and your baby:

- Certified Nurse-Midwives*;
- Family Practice Physicians;
- Licensed Midwives*;
- Nurse Practitioners;
- Obstetricians; and
- Physician Assistants.



Services for pregnant women may include:

- Prenatal care;
- Case Management;
- Childbirth education;
- Doula services (where available);
- Birthing services for Labor and Delivery;
- Postpartum care;
- Breastfeeding counseling;
- Reproductive Health; and
- Family planning.

If you would like to select out-of-hospital services provided by a midwife*, please send the following information by mail:

- Your name;
- Your address;
- Your telephone number;
- Name of midwife; and
- Telephone number for the midwife you have chosen.

Mail this information to the following address:

Pregnancy-Related Services Benefits Bureau HSD-MAD
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Or call the Medical Assistance Division toll free at (888) 997-2583.

For more information about the services that are provided by midwives*, please contact:

New Mexico Midwives Association*

Toll free at (888) 332-4784 or in Albuquerque at (505) 924-2169.
<http://www.newmexicomidwifery.org>

American College of Nurse-Midwives New Mexico Chapter

<http://nmmidwives.org/practices.php>

Maternal Health Program Department of Health

In Albuquerque at (505) 476-8908.

**These services are only covered if they are provided by healthcare providers who have an approved Provider Agreement with the Human Services Department/ Medical Assistance Division.*

TRANSPORTATION

Does Centennial Care pay for Transportation?

Members who can transport themselves must do so. If you have been taking yourself to your practitioner/provider visits, you must continue to do so.

Transportation based on medical necessity is a covered benefit in the Centennial Care Program. It is for members who have no other means of transportation.



The provider for transportation is Integrated Transport Management (ITM). You can contact ITM to let them know if there are special needs with your case.

Transportation can only be used to go to medical or behavioral health visits. The service is only good to see the practitioner/provider that has been approved by Molina Healthcare. The Centennial Care Program does not cover transportation to the store or to see a friend.

ITM will call Molina Healthcare and check to see that your medical visit has been approved. This must be done before they can approve

transportation. For non-emergency transportation, you must give ITM at least two (2) working days' notice.

What are ITM's Hours of Operation?

ITM has regular business hours Monday - Friday from 7:00 a.m. to 5:00 p.m. and Saturday from 8:00 a.m. to 1:00 p.m.

ITM is open twenty-four (24) hours a day, seven (7) days a week for urgent calls.

What is ITM's Telephone Number?

The toll free number is (888) 593-2052.

How do I Get Routine Transportation?

ITM must be notified two (2) working days before your visit. It takes time to arrange for transportation. ITM needs to know:

- Your address and telephone number;
- Your ID number;
- Where you are going;
- Who you are seeing;
- The practitioner/provider address and telephone number; and
- The day and time of your visit.

After ITM has this information, they will call the practitioner/provider. ITM will confirm the visit. ITM will then set-up the transportation. ITM will call you back with the time of pick-up.

Will Molina Healthcare pay me to use my own car for transportation?

Yes, Molina Healthcare can pay for this. But only if certain things are done first:

- ITM must approve the visit before you go;
- You must keep receipts for gas;
- Your visit must match the day you are asking Molina Healthcare to pay you back; and
- ITM must confirm you went to the visit before Molina Healthcare can pay for the trip.

What if I have been using my car and the day of my appointment the car breaks down?

Call ITM and tell them what the problem is. Just like with routine transportation, ITM needs this information:

- Your address and telephone number;
- Your ID number;
- Where you are going;
- Who you are seeing;
- The practitioner/provider address and telephone number; and
- The day and time of your visit.



ITM will set up the transportation once they have this information. ITM will call you back with the time of pick-up.

Does Centennial Care pay for housing and food?

The transportation benefit may also pay for housing and food. This is if you go out of town for a medical or behavioral health visit. This is only if the trip is longer than four (4) hours one-way by ground transportation. ITM will tell you if you can do this.

You must keep your receipts for housing and food. There are limits to the amount of housing and food that Centennial Care will pay for. Copies of these receipts must go to ITM. ITM can directly pay for food and housing in advance. ITM can tell you how much they are allowed to pay for. ITM is happy to help you with questions about housing.

What if I need transportation outside of the State of New Mexico?

ITM does not contract for transportation or housing outside of the state. If the Molina Healthcare Medical Director has approved the need to go out of state, a Case Manager will make the arrangements.

What if I have a need for urgent or same-day transportation?

ITM will ask you a series of questions. This is to decide how urgent the transportation need is. They are trying to figure out if you need an ambulance or a taxi. ITM is open twenty-four (24)

hours a day, seven (7) days a week for urgent calls. Below are examples of questions they may ask:

- Do you have a fever?
- Are you on oxygen?
- Do you use a wheelchair or walker? or
- Are you coughing?

An example would be a child who has a high fever. He/she needs to go to the hospital, but he/she does not need an ambulance. This is an example of an urgent call.

What if the transportation is a true emergency?

While ITM is talking to you and if the case sounds like a true emergency, ITM will tell you to hang up the telephone and call 911. ITM will take care of paying for the ambulance later. Do not call ITM first if you think a problem is a true emergency. Please call 911.

What if my underage child needs to go to a medical appointment and I cannot go?

ITM will need you to sign a waiver saying that it is okay for them to transport the child. It is very important that you make every effort to go with your child. This will help you to understand your child's problem. Many practitioners/providers will not treat a child without a parent there. If you do not sign a waiver, or go with your child, there is a chance the driver will not transport your child.

What if I have a problem with transportation?

Sometimes problems happen with transportation. We want to know if there is a problem. Please call Customer Support Center with any concerns.

We are always trying to improve our service to you. We cannot make services better if we do not know about a problem. Please call Customer Support Center if ITM cannot help you with your questions or problems.

SERVICES REQUIRING PRIOR AUTHORIZATION (Approval)

A prior authorization is a review of the service that has been asked for. The service will need to be looked at by the Medical Director. The nurse or Medical Director will decide if the test, service, equipment or procedure meets the criteria for “medically necessary” care or treatment. Within one (1) to seven (7) days, both the patient and the PCP will be told if an authorization or a denial is given. If a denial is given, the patient and/or provider can appeal the decision.

What are Prior Authorizations (Approvals) and Specialist Referrals?

Some services and prescriptions need an Approval. Molina Healthcare gives a Prior Approval to you and your provider for certain services. For example:

- You will need an Approval from Molina Healthcare for all services performed by an out of plan provider; and
- You will need an Approval from Molina Healthcare for all nonmedically necessary services.

Your PCP or specialist will decide if you need this type of service. Your PCP or specialist will ask Molina Healthcare for the approval. Molina Healthcare must approve the services before you get them. If you get services that Molina Healthcare does not approve, you may have to pay the bill. A referral is from your PCP to a Molina Healthcare specialist. This does not need to be approved by Molina Healthcare. If you have questions about services that need an Approval or referral, call Customer Support Center. Call us in Albuquerque at (505) 342-4681 or toll free at (800) 580-2811.

The following is a list of some tests and procedures that will need a prior authorization:

Heart station procedures:

- Dobutamine ECHO

Radiology/imaging procedures:

- MRIs;
- PET Scanning;

- Interventional Radiology; and
- CT Scans.
- Elective inpatient admission;
- Neuropsych testing;
- Physical, Occupational and Speech therapies (after initial consultation and treatment visit);
- Inpatient rehabilitation services;
- Home health services;
- Durable Medical Equipment;
- Oral and reconstructive surgery;
- Inpatient behavioral health and detoxification;
- Pain Management services; and
- Sleep Studies.

Service Limitations

Covered services are subject to the following conditions and limitations:

1. Medically Necessary services are clinical and rehabilitative, physical, mental or behavioral health services that are:
 - Necessary to prevent, diagnose or treat medical conditions;
 - Necessary to allow the member to reach, maintain or recover maximum function;
 - Given in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the member;
 - Given within professionally accepted standards of practice and national guidelines; and
 - Needed to meet the physical, mental and behavioral health needs of the member and are not primarily for the convenience of the member, the provider or the payer.
2. Choice of Provider. For the purpose of coverage under this policy, Molina Healthcare has the right to decide which practitioner/provider can be used to provide the covered services.
3. Contact Lenses or Eyeglasses. Following Cataract Surgery One (1) complete set of contact lenses or eyeglasses is covered following surgery for the removal of cataracts from one or both

eyes. Coverage is limited to either one (1) set of contact lenses or eyeglasses per member per surgery. The maximum amount of coverage for materials (contact lenses or eyeglasses) is limited to \$300 per surgery. Coverage for contact lenses or eyeglasses is limited to ninety (90) calendar days following surgery for the removal of cataracts. Contact lenses or eyeglasses obtained after the ninety (90) calendar day period are not covered.

4. **Dental Services.** In cases of accidental injury to sound natural teeth, the jawbones or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within seventy-two (72) hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury must be properly noted during the initial treatment. Services must be completed within twelve (12) months of the date of injury.
5. **Home Health Services.** If home health services can be provided in more than one medically appropriate setting, the MCO may choose the setting for providing the care.
6. **Major Disasters.** In the event of any major disaster, epidemic, or other circumstance beyond its control, Molina Healthcare will provide or attempt to arrange covered services with participating practitioners/providers as practical using its best judgment and within the limitations of facilities, supplies, pharmacies and personnel available. Such events include:
 - Complete or partial disruption of facilities;
 - War;
 - Riot;
 - Civil uprising;
 - Disability of participating providers; or
 - Act of terrorism.
7. **Maternity Transportation.** Coverage for transportation is given when medically necessary to protect the life of the infant or mother. This includes air transport if needed, for medically high-risk pregnant women with an impending delivery of an infant, to the nearest available care center.
8. **Mastectomy and Lymph Node Dissection.** Length of inpatient stay: not less than forty-eight (48) hours inpatient stay following a mastectomy and not less than twenty-four (24)

hours of inpatient care following a lymph node dissection when deemed medically appropriate by physician and patient.

9. Orthotic Appliances and Prosthetic Devices. Repair or replacement of orthotic appliances and prosthetic devices due to normal wear.
10. Physical, Speech and Occupational Therapy. Physical, occupational and speech therapy services which are reasonable and necessary for the treatment of the member's specific condition.
11. Post Mastectomy Supplies. Bras required in combination with reconstructive surgery are limited to two (2) per member per benefit year.
12. Prescription Medication. Prescription Medication are limited to generic medication and name brand prescription medication. They are listed on the drug formulary. For each co-payment amount, quantities are limited to a thirty (30) calendar day supply or one hundred (100) tablets, whichever is less, per prescription or refill. All other units will be given in a thirty (30) calendar day supply.
13. Transplants. The following transplants are covered as long as the indications are not considered experimental or investigational:
 - Heart;
 - Lung;
 - Heart/Lung;
 - Liver;
 - Kidney;
 - Bone marrow; and
 - Cornea.

Molina Healthcare has the right to require that transplants be performed at contracted Centers of Excellence if one is available.

Services Not Covered (Exclusions)

Molina Healthcare does not cover services or supplies that are not specifically listed as a covered service. If a service is not a covered service, then all services performed in conjunction with the non-covered service are not covered as well. The list of exclusions below is not a complete listing, but is meant to be of help to members. If a service is not listed as a covered service, then it is not covered regardless of medical necessity. Other services that are not covered are:

1. Services not coordinated through a member's PCP or lacking a prior Authorization (approval). Health services and supplies are not covered if they are not provided by or under the direction of:
 - A. The member's PCP or a practitioner/provider to whom the member has been referred by his PCP;
 - B. A non-participating practitioner/provider to whom the member has been referred by his PCP, and a prior authorization is in place for those services; or
 - C. A service or supply that requires a prior authorization if a prior authorization is not obtained.
2. Services not medically necessary, not standard medical practice or experimental. The following services are not covered:
 - A. A treatment, procedure, facility, equipment, medication, drug use, device or supply that is not medically necessary. Molina Healthcare only pays for medically necessary services given by approved providers to eligible members. Molina Healthcare does not cover experimental or investigational medical, surgical or other health care procedures or treatments, including the use of drugs, biological products or other products or devices, except routine patient costs associated with certain Phase I, II, III and IV cancer clinical trials.
 - B. Drugs and devices that are not Federal Drug Administration (FDA) approved for the proposed use or which have been voluntarily removed from the market.
 - C. Medical, surgical, and/or behavioral health procedures, pharmacological regimes, and/or related health services, if they are experimental, under investigation or generally not standard medical practice.
3. Acupuncture and Chiropractic Services. These services are not covered.
4. Assistant Surgeon Services. Payment for assistant surgeon services when Molina Healthcare does not approve an assistant surgeon is not covered.
5. Cosmetic Services. Cosmetic services are not covered, including but not limited to:
 - Surgery, services or procedures to change family characteristics or conditions due to aging;
 - Dermabrasion;
 - Scar reconstruction or revision;

- Acne surgery (including excision of scarring & cryotherapy); tattoo removal;
 - Orthognathic jaw surgery; services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body; surgical excision or reformation of sagging skin on any part of the body including, but not limited to eyelids, face, neck, abdomen, arms, legs or buttocks; microphlebectomy;
 - Sclerotherapy; liposuction; rhinoplasty; otoplasty;
 - Services related to a cosmetic service or needed as a result of a non-covered cosmetic service; surgery needed as a result of a non-covered procedure (such as a non-covered organ or tissue transplant or a sex change operation); or
 - Breast augmentation, reduction mammoplasty or nipple reconstruction except as related to reconstructive surgery.
6. Court Ordered Care .Court mandated evaluations and treatment that would not comply with the terms and conditions of the Centennial Care contract are not covered.
 7. Coverage Out of the Service Area. Coverage while away from the service area, except for emergency health services and urgently needed health services, is not included, unless otherwise covered.
 8. Bariatric (weight loss) Surgery. Bariatric surgery and related expenses.

Non-Covered Services for Long Term Care include:

1. Services provided in intermediate care facilities for the mentally retarded (ICF/MR)
2. Emergency services to undocumented aliens
3. Experimental or investigational procedures, technologies or non-drug therapies
4. Case management services provided by the children, youth and families department that are defined as child protective services case management.
5. Case management services provided by the aging and long-term services department
6. Services provided in the school and specified in the Interdisciplinary Education Plan (ISP)

Non-Covered Services for Behavioral Health Services include:

1. Hypnotherapy
2. Biofeedback
3. Services which do not meet the standard of medical necessity as defined in MAD rules
4. Conditions defined as international classification of disease that are not treatable and do not meet MAD definition of medical necessity:
 - treatment for personality disorders for adults age 21 and older
 - treatment provided for adults 21 and older in alcohol or drug residential centers
 - milieu therapy
 - educational or vocational services related to traditional academic subjects or vocational training
 - experimental or investigational procedures, technologies or non-medication therapies and related services
 - activity therapy, group activities and other services which are primarily recreational or diversional in nature
 - services provided by non-licensed counselors, therapists or social workers
 - treatment of mental retardation alone.

Call Customer Support Center for questions about covered and non-covered services. Molina Healthcare will also tell you if your benefits have changed.

Additionally, Non-covered services that do not have prior approval will not result in the loss of Medicaid Benefits.

EMERGENCY/URGENT SERVICES

Emergency Care

An emergency is when you need care right away. You need emergency care because you have an injury or sudden illness. A prior authorization is not required for emergency services.

Here are some examples of emergencies:

- Broken bones;
- Bleeding that does not stop;

- Heart attacks;
- Major burns; or
- Drug overdoses.

What to do if you have an emergency

Call 911 if you have a serious health problem or accident. You can also go to the nearest emergency room (ER). Tell the ER person who your PCP is. Call your PCP as soon as you can to let him/her know about your emergency.

Follow-up care is not an emergency.

You should call your PCP's office to set up follow-up care if you need it. You can also call Customer Support Center for help setting follow-up care.

Do not go to the emergency room for care you can get in your PCP's office. Call the Molina Healthcare 24-Hour Nurse Advice line if you have questions about using the emergency room.

The Molina Healthcare 24-Hour Nurse Advice line is available twenty-four (24) hours a day, seven (7) days a week. You can use it if you are sick, injured or not feeling well. Qualified nurses will speak with you. They will help direct you to the right care.



If you are not able to reach your PCP or speak with the practitioner on-call, you can contact Molina Healthcare's 24-Hour Nurse Advice Line. Call toll free (888) 275-8750 for an English-speaking representative. Or call toll free (866) 648-3537 for a Spanish-speaking representative.

Here are some examples of when you should not use the emergency room:

- Sore throats;
- Cold or flu;
- Back pain; or
- Tension headaches.

Do not wait until after office hours to get care for you or your family.

Getting Emergency Care While Traveling

Go to the nearest emergency room if you are very sick. Go if you are badly injured and need treatment right away.

Call your PCP within forty-eight (48) hours after getting emergency care. Tell him/her what kind of care you got.

Customer Support Center or Molina Healthcare's 24-Hour Nurse Advice Line can help you with medical care information. We can do this when you are traveling.

How to Get Services when you are outside the State of New Mexico Emergency services are the only services that will be paid when you are outside of New Mexico. A prior authorization (approval) is not needed before you get emergency care. If you have an emergency, go to the nearest emergency room. Tell them you are covered by Molina Healthcare. Show them your Molina Healthcare ID card.

After Emergency care, call your PCP within forty-eight (48) hours. Tell him/ her what kind of care you got.

If you are sick but it is not an emergency, call the Molina Healthcare 24-Hour Nurse Advice Line. Call toll free (888) 275-8750 for an English-speaking representative. Or you can call toll free (866) 648-3537 for a Spanish-speaking representative.

Urgent Care

Urgent care is when you must get treatment within eighteen (18) to twenty-four (24) hours. Check with your PCP first before you get urgent care. Your PCP should see you if the urgent need is during regular office hours. If they cannot see you, they will send you to an Urgent Care office or to the emergency room (ER). Call Customer Support Center if there are problems getting in to see your PCP. We will try to help you be seen.

How to Get Services After Hours

Call your PCP if you think you need urgent medical care. If you cannot reach your PCP or the practitioner/provider on-call, call the Molina Healthcare 24-Hour Nurse Advice Line. Call toll free (888) 275-8750 for an English-speaking representative. Or you can call toll free (866) 648-3537 for a Spanish-speaking representative.

Contact with your PCP

If you get emergent or urgent care, you should tell your PCP within forty-eight (48) hours. Your PCP may need to see you for follow-up care.

Your PCP will need to get copies of the records from the emergency room or urgent care visit. Sometimes hospitals do not send these records right away or the records may get lost. This will make it very hard for the PCP to be able to help you or your family member. Remember that practitioners/providers and nurses need this information to help you. You might have to help get the records.

Information to take to the Emergency Room

It is important to take information about yourself to the Emergency Room. You should have information about:

- Medications you are taking (including over the counter medication);
- Allergies;
- Diagnoses;
- PCP or specialist names and telephone numbers;
- Medical equipment provider (if you have one);
- Pharmacy; and
- Home care provider (if you have one).

What to do if you have an Emergency need for Durable Medical Equipment (DME)

Some DME, like oxygen or a ventilator, is very important. It can be serious if the machine breaks or the oxygen tank runs out. Call your DME provider for help if you have an emergency with your DME. Keep their telephone number where you can find it. You can put the telephone number on the equipment. You can put the telephone number on your refrigerator. This will help you find the number in an emergency.

Call 911 if you are in immediate danger. You can get emergency DME from your DME provider. You do not have to contact Molina Healthcare. Your DME provider will get approval later.

Reorder supplies you use on a regular basis. Order them from your DME provider. Supplies can be ordered during regular business

hours. Molina Healthcare can give a prior approval for some DME supply refills. These referrals may last as long as one (1) year. Call your DME provider if your DME is not working as it should. Call them during regular business hours for help.

Call Customer Support Center if you cannot get the help you need from your DME provider. We have someone on call twenty-four (24) hours a day, seven (7) days a week, for urgent or emergency needs. We will help you get the DME supplies and equipment that cannot wait until the next day.



PHARMACY SERVICES

Filling Prescriptions

There may be times when your practitioner or provider prescribes a medication for you. The prescriptions for your medications can be filled at most retail pharmacies.

Molina Healthcare has a list of medications that can be prescribed for you by your practitioner/provider. This list is given to PCPs and specialists. Your PCP can tell you if the medication you need is on the list. If the medication is not on the list (Formulary), your PCP has to get approval. Your PCP must submit an authorization form to Molina Healthcare. The authorization form (also called a prior authorization) should explain why you need a medication that is not on the list. You can access our website to view a list of medications that are on our approved list. The website is www.molinahealthcare.com or www.mymolina.com. At the website, select 'Member' and the State of 'New Mexico'. Select the tab labeled 'Drug Formulary.' On this page, you can select either 'Brand Name' or 'Over-the-Counter Formularies.' You can look at the website to find a Pharmacy provider by selecting 'Find a Pharmacy.' If you have questions, please call Customer Support Center.

Call Molina Healthcare if you have questions about the medication list or prior authorizations. The toll free number is (800) 580-2811. After business hours or on holidays, call the toll free Nurse Advice Line for questions about the medication list or for pharmacy information. To talk to a nurse in English call toll free (888) 275-8750. To talk to a nurse in Spanish call toll free (866) 648-3537. Your Provider Directory also has pharmacy location information.

Medication Refills

The pharmacy can give you a refill on your medication. You can get a refill if your doctor has ordered one. The pharmacy cannot refill your medication more than five (5) days before the refill date. They cannot refill it before three-fourths (3/4) of your medication has been used.

Questions about Medication

The pharmacist can answer questions you have about your medication. Make sure you know how to take your medication. Tell the pharmacist if you have allergies to medication or foods. Tell your PCP and pharmacist about other medications, vitamins or herbal remedies you are taking.

If you are having problems with your medication, talk to your practitioner/ provider right away. Your practitioner/provider needs to know if you are having problems.

Exceptions to Denied Medications

Molina Healthcare uses a special list of medications. It is called a Drug Formulary. Your doctor can ask Molina Healthcare to cover a medication that is not on this list. This is called an “exception”.

Your doctor can ask for a prior authorization. They ask Molina Healthcare for the prior authorization. If your doctor’s request for an exception is not approved, you have a right to appeal that decision. You have a right to get another review. You will get a denial letter from Molina Healthcare. Your doctor will get a denial letter from Molina Healthcare. The letter will tell you how to ask for an appeal.

INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (ISHCN)

Choosing a Specialist as a PCP (ISHCN)

An Individual with Special Health Care Needs can have a specialist act as their PCP. The member must get a written note from the specialist they want as a PCP. The specialist must agree to act as a PCP for that member. The specialist must send a note to Molina Healthcare’s Healthcare Services Department. The note must include the reason for using the specialist as a PCP.

Send the written note to:

Molina Healthcare of New Mexico, Inc.

ATTN: Healthcare Services

P.O. Box 3887

Albuquerque, NM 87190-9859



The specialist can fax the note toll free to (888) 802-5711. If you need a specialist as a PCP, the specialist must agree to meet the minimum requirements of Molina Healthcare's PCP care.

When Molina Healthcare gets the note from the specialist, it is sent to the Medical Director for review. The Medical Director reviews the note for medical need.

The specialist must write that they are willing to act as your PCP. The note must show there is a medical need for the specialist to act as your PCP. The request will be denied if the specialist does not want to be your PCP. The request will be denied if the note does not show why the specialist must act as a PCP. You and the specialist will be told of the denial by telephone. The call will happen within twenty-four (24) hours of the denial decision. You and the specialist will also be told in writing. You will get this notice within two (2) working days after the denial decision. You will also be told of your appeal rights. You will be told of your right to select a different PCP.

Behavioral Health Services for Individuals with Special Health Care Needs (ISHCN)

Behavioral health services are now provided through Molina Healthcare. If you have questions, you can call Customer Support Center toll free at (800) 580-2811.

How to Arrange for Transportation for Individuals with Special Health Care Needs (ISHCN)

Members who can transport themselves should do so. If you have been taking yourself or your dependent to the practitioner/provider, you must continue to do so. Medically necessary transportation is a covered benefit in the Centennial Care Program. It is for members who have no other means of transportation. This is talked about more in the transportation section of the Member Handbook. Molina Healthcare provides transportation for behavioral health.

What to do if an Individual with Special Health Care Needs has an emergency

An emergency is when you feel you or your dependent's life or limb is immediately threatened. Call 911 if this is the case. The Centennial Care Program pays for true emergencies. You can get this service without an approval from Molina Health care. It is important to get treatment first and take care of paperwork later.

HEALTHCARE SERVICES (HCS) INFORMATION

What is Healthcare Services (HCS)?

We want to make sure you are getting the right kind of medical care. Our (HCS) staff work hard to make sure you do.

There are times when the care you need requires prior approval from Molina Healthcare. This is when our (HCS) staff looks at your medical needs. This is to make sure the kind of medical care being asked for is the best care for you. Only a Medical Director can decide if your medical care will not be approved. This is based on medical necessity. Our practitioners/providers and nurses do not get any money or compensation for denying services or payment for care.

After you get medical care, Molina Healthcare looks at your records. This is to make sure you got the medical care you needed. This (HCS) review helps us make sure that you got the right care. If you have questions, call Customer Support Center between 8:00 a.m. and 5:00 p.m., Monday – Friday (except holidays).

You will need an Approval from Molina Healthcare for all services performed by an out of plan provider; and

You will need an Approval from Molina Healthcare for all non-medically necessary services. Your PCP or specialist will decide if you need this type of service. Your PCP or specialist will ask Molina Healthcare for the approval. Molina Healthcare must approve the services before you get them. If you get services that Molina Healthcare does not approve, you may have to pay the bill.

A referral is from your PCP to a Molina Healthcare specialist. This does not need to be approved by Molina Healthcare.

If you have questions about services that need an Approval or referral, call Customer Support Center. Call us in Albuquerque at (505) 342-4681 or toll free at (800) 580-2811.

How to Get PCP, Specialist or Hospital Services

You should make an appointment with your PCP when you pick one. It is important to meet your PCP. Make an appointment even if you are not sick. This will help your PCP get to know you.

The PCP will check your medical history. The PCP does this to help keep you healthy. The visit is part of your preventive benefit. You need to see your PCP if you think you need hospital care that is not an emergency.

Your PCP must refer you if you need to see a specialist. Your PCP will give you a referral form. You must take the referral form with you when you go to see the specialist.

You must make sure the specialist is part of the Molina Healthcare network. You can do this by calling Customer Support Center. Do not get care without asking your PCP first. You may have to pay the bill if you do.

What is Care Coordination?

Care Coordination is a service offered to all members of Molina Healthcare. Care Coordinators will conduct Health Risk Assessments, Comprehensive Needs Assessments (CNA) and Re-assessments for Members assigned to them. Your Care Coordinator will determine your medical, behavioral and long-term care needs from these assessments. Care Coordinators ensure that Molina staff for medical, behavioral and long-term care are aware of all of your needs and treatments when reviewing requests for services. Your Care Coordinator can also provide you with resources for food, shelter, clothing, senior citizen centers, support groups and other community resources.

If you are in the Agency Based Community Benefit, your Care Coordinator will formulate your Comprehensive Care Plan based on your needs as identified in the CNA.

If you are in the Self Directed Community Benefit, your Care Coordinator will work with you to train you about Self Direction, develop a Comprehensive Care Plan, monitor usage of your budget

to ensure that spending is on track with the budget and provide oversight of your Supports Broker,

How to Contact Your Care Coordinator

During business hours 8:00 AM to 5:00 PM

- Your Care Coordinator has a direct dial phone number. You can also use Molina's toll-free number and enter your Care Coordinator's 6-digit phone extension.
- If you do not know the name of your Care Coordinator or their phone number, you may call 1-800-280-5811 and you will be connected to your Care Coordinator.
- If you have not yet been assigned to a Care Coordinator, you may call 1-800- and you will be connected to a Care Coordination team who will assist you.

After business hours 5:00 PM to 8:00 AM

- Call our Nurse Advice Line at 1-800-278-8750. The Care Coordination teams have an on-call Care Coordinator available to assist you.

Goals of Care Coordinators

Care Coordinators are here to support you. They respect your dignity as a human being. The goal of Care Coordination is to help our members. Our goal is to promote these values:

- Support you in your right to make your own choices;
- Provide services that are sensitive to your cultural needs;
- Not impose personal values on you;
- Support you in becoming more independent;
- Allow you the support systems and relationships to be included in planning;
- Provide services during your transition from another health plan;
- Give you Care Coordination that helps with your needs and supports building personal strengths; and
- Give you help at all times.

The Woman's Health & Cancer Rights Act

Molina Healthcare has benefits for mastectomy-related medical conditions. This is part of the Women's Health and Cancer Rights Act of 1998. Call Customer Support Center if you have questions.

HEALTH IMPROVEMENT SERVICES

Staying Healthy

We want to help you stay healthy. We have many health education programs for you. They cover topics such as:

- Asthma;
- Parenting;
- Helmet safety;
- Diabetes;
- Heart health;
- Chronic Obstructive Pulmonary Disease (COPD);
- Cardiovascular disease;
- Nutrition;
- Pregnancy and car seat safety;
- Quitting smoking; and
- Weight management.

Call the Health Improvement Hotline for a list of classes and services you can get. In Albuquerque, call (505) 342-4660, extension 182618. Or call toll free (800) 377-9594, extension 182618.

Preventive Health Guidelines/Well-Child Health Check

The well child health check, or EPSDT Program, stands for Early and Periodic Screening, Diagnostic and Treatment. It is a special program for Centennial Care members. It is available from birth through twenty-one (21) years of age. The program gives your child regular well-child check-ups, immunizations and medical care to keep them healthy.



Please see the Preventive Health Guideline charts. They are included at the end of this handbook. They tell you when you should see your practitioner/provider for preventive care. They let you know the tests and care you should get during each visit. Visits can be for a child, adolescent, adult or pregnant woman.

Rewards for Healthy Choices

Did you know that you can get a gift card for taking care of your health? Gift cards are given to Molina Healthcare members when they get certain preventive health check-ups and screenings completed. To download the reward coupons, go to our website at www.molinahealthcare.com. Or you can call the Health Improvement Hotline in Albuquerque at (505) 342-4660, extension 182618 or toll free at (800) 377-9594, extension 182618. Your PCP can fax or mail the coupons to:

Molina Healthcare of New Mexico, Inc.
Attn: Health Improvement
P.O. Box 3887
Albuquerque, NM 87190-9859
Fax: (505) 798-7315



Health Screening/ Test	Description	Incentive	Target
Diabetes – Part 1	Members who have diabetes who complete the following: <ul style="list-style-type: none">• Retinal Eye Exam• Nephropathy screening (Kidney)• LDL Cholesterol screen	\$20 Walmart Gift Card	Centennial Care
Diabetes Part 2	Members who have diabetes who complete the following: <ul style="list-style-type: none">• Blood pressure screen• HbA1c	\$20 Walmart Gift Card	Centennial Care
Asthma Care	Members who have asthma who complete the following: <ul style="list-style-type: none">• Doctor's visit for asthma care that includes:<ul style="list-style-type: none">▶ Asthma Action Plan▶ Asthma medication (long term controller)▶ Peak Flow Meter	\$20 Walmart Gift Card	Centennial Care
Mammogram	Members who complete a mammogram every year or as recommended by their doctor	\$20 Walmart Gift Card	Centennial Care
Postpartum Check Up	Members who receive a postpartum checkup within 3 to 8 weeks after delivering their newborn.	Toddler (Convertible) Car Seat	Centennial Care

Cervical Cancer Screening	Members who complete a Pap smear every year or as recommended by their doctor	\$20 Walmart Gift Card	Centennial Care
Dental Care	Members age 0-21 years who complete a preventive dental exam each year	\$20 Walmart Gift Card	Centennial Care
Well Child Check Up 3-6 Years Old	Members who are 3 to 6 years old who get their yearly well child checkup that includes physical exam, immunizations, vision and hearing screening and dental.	\$20 Walmart Gift Card	Centennial Care



Care Management Services

Molina Healthcare has Care Management services for you. We can help you if you have diabetes, asthma or heart disease. We can help you if you are pregnant. Molina Healthcare wants you to know all you can to help you stay healthy. These programs can help you better manage your condition. You may be enrolled in a program automatically based on claims by your provider/ practitioner. You can also enroll yourself. Or your provider/practitioner can send a referral. It is your choice to be in these programs. If you don't want to be in any of the programs let us know.

Call us to learn more about these programs. You can call us toll free at (800) 377-9594, extension 182618. In Albuquerque, you can call us at (505) 342-4660, extension 182618.

*breathe with ease*sm Asthma Program

Molina Healthcare has classes and educational materials to help you if you have asthma. We also have peak flow meters and other services to help you if you have asthma.

Children ages five (5) to eleven (11) who are enrolled in the *breathe with ease*sm Asthma Program and who complete the Asthma Action Plan can qualify for an incentive. Enroll your child today for this education program.

You can start taking control of your asthma. Learn about:

- What triggers your asthma;
- What you can do about your asthma triggers;

- What to do for asthma attacks;
- How to use your medicines; and
- How to make an asthma action plan with your practitioner/provider.

Healthy Living with Diabetes™

Molina Healthcare has classes and educational materials to help you if you have diabetes. We also have other services if you have diabetes. Diabetes is a common but serious disease. It makes it hard for your body to use food as energy.

If you have diabetes, it is important for you to learn:

- What diabetes is;
- How it changes the way your body turns food into energy;
- How to control your diabetes with blood sugar monitoring;
- How to control your diabetes by eating the right foods and exercising;
- How to take medicines if your PCP orders them;
- How to take care of your body and prepare for special situations;
- How to cope with your emotions; and
- Where to turn when you need support.

Heart Healthy Living Cardiovascular Disease Program

Molina Healthcare's cardiovascular disease (CVD) program helps adults eighteen (18) years and older with support and education. This includes education, case management and resources to help manage heart disease.

Healthy Living with COPD (Adult Chronic Obstructive Pulmonary Disease) Molina Healthcare has a program for adults age thirty-five (35) years or older to help manage COPD, including education, case management and support. Care managers work with members and their PCP to develop action plans, manage medications and reduce triggers for healthy control.

motherhood matterssm Pregnancy Program

Molina Healthcare has a program for pregnant members. The

program is called the ***motherhood matterssm*** Pregnancy Program. We care about the health of our pregnant members and their new babies. You get support and care when you are in our ***motherhood matterssm*** Pregnancy Program. You will be given extra education, guidance and resources. Pregnant members who enroll can qualify for a free infant car seat. Call before your thirty fifth (35th) week of pregnancy to register.

Positive Parenting Program

Molina Healthcare offers parents of small children useful tools to help improve their parenting skills. Tools are provided to help set limits, deal with anger and discipline issues, praise children and communicate with teens.

Helmet Safety Program

Molina Healthcare offers a helmet safety education program for children to help them learn more about being safe and staying healthy as they ride their bike, scooter, skateboard or roller blades. Members will receive a free bike helmet.

QUIT NOW[®] Tobacco Cessation Program

Are you a Molina Healthcare member who is ready to quit smoking? We can help you. The Quit Now program can help you quit tobacco and stay healthy. A quit coach will help you make good decisions about medications. They will help you develop new skills to help you get ready to quit smoking. They will teach you how to act differently in situations that involve tobacco so you can stay quit. Call Quit Now at (800)QUIT NOW or (800)784-8669.

Healthy Weight Programs

Molina Healthcare has online weight management resources to help members stay healthy.

- ***SparkPeople.com*** offers free online health, nutrition and fitness resources.
- ***Babyfit.com*** is for pregnant mothers to help stay healthy during pregnancy and after delivery. This includes breastfeeding information and parenting tips.
- ***SparkTeens.com*** is for teens thirteen (13) to seventeen (17) years old and offers healthy weight tools including nutrition and exercise tips.

Health Education and Health Literacy

Molina Healthcare has developed health education programs to increase education and health promotion services. The Health Education Program consists of Health Educators, including Certified Health Education Specialists (CHES), that administer health and wellness programs designed to improve health and wellness outcomes and to ultimately impact health disparities. The Health Educator's ultimate responsibility is to educate people for the purpose of promoting, maintaining, and improving individual, family, and community health. The Health Educator is professionally prepared to serve in a variety of roles and is trained to use appropriate educational strategies and methods to facilitate the development of policies, procedures, interventions, and systems conducive to the health of individuals, groups, and communities. The Health Educator has extensive knowledge on how to effectively coordinate and educate Members, provides a wide range of outreach and assistance, and understands the special needs of Centennial Care populations, many of who may have multiple diagnoses, including mental illness.

The Health Education Plan includes a comprehensive program description of member health education that includes classes (individual or group) and appropriate methods (videotapes, written materials, media campaigns and modern technologies). All instructional materials shall be provided in a manner and format that is easily understood and compliant with contract requirements.

Health Educators will collaborate with Molina Healthcare's Care Managers and Community Connectors (community health workers) to assist in promoting health education, preventive services conducting assessments, promote health literacy, and serve as resources.

Community Connectors are bilingual and bicultural paraprofessionals (interpretation and translation services are available) specially trained to serve as Member navigators and promote health with in the Members' communities; educate Members on prevention and chronic disease management; provide informal counseling and guidance on health behaviors; assist Members in establishing a medical home and accessing community-based services, and ensuring the Member receives all Medically Necessary Covered Services Health education

programs actively identify members who require intervention and provide culturally appropriate education while also involving the member's PCP. Contact with the identified members includes, at a minimum, the following:

- a. Education about preventive, early detection and/or treatment and resources available to address specific age categories and/or conditions;
- b. A referral or recommendation to participate in a program to benefit and improve the member's health status;
- c. The availability and benefits of preventive healthcare;
- d. Targeted disease management education;
- e. The benefits of completing Advance Directives;
- f. Education on the availability and benefits of Health Homes;
- g. Teaching on the importance of EPSDT services;
- h. Instruction on the risks associated with the use of alcohol, tobacco and other substances; and
- i. Coaching on the concepts of managed care.

Requests for health education materials, classes, or resources for Members are submitted through the Health Education/Health Management Referral Form. Health education referrals can be initiated by Members, practitioners/providers, hospital/clinic staff, internal departments, care managers/case managers, and community-based organizations.

Requests for a practitioner/provider, hospital or clinic assessment of health education needs can be submitted using the Health Education/Health Management Referral Form. Health education assessments are available to all contracted practitioner/provider or facilities.

Referrals for health education services can also be directed to the Health Improvement Hotline toll free at (800) 377-9594 extension 182618 or in Albuquerque at (505) 342-4660 extension 182618. Health Education/Health Management Referral Forms can be faxed to (505) 798-7315.

COVERAGE AND ELIGIBILITY

HSD decides eligibility for enrollment in Centennial Care. All Medicaid clients must enroll in Centennial Care except for Native Americans.

Members entering Molina Healthcare will not be held responsible by practitioners/providers for the costs of medically necessary services except for applicable cost sharing. Unless the member self-refers to a specialist or other provider without following Contractor procedures.

Switching to another Managed Care Organization (MCO)

Your enrollment with Molina Healthcare runs for a twelve (12) month cycle. During the first ninety (90) days of enrollment with Molina Healthcare, you have the right to switch to a different Managed Care Organization (MCO). If you choose to switch, you will have another ninety (90) days to decide if you want to switch to another plan. If you switch plans and return to Molina Healthcare then you will stay enrolled with Molina Healthcare until the end of the twelve (12) month cycle.

If you ask to switch to another MCO, you can do this at renewal or recertification of your eligibility with the ISD office. At any other time you can switch to another MCO “for cause” as defined by the Human Services Department (HSD). You must ask for this switch in writing. Make your request to HSD. Some reasons for switching from Molina Healthcare include:

- Maintaining continuity of care;
- Allowing family members to all belong to the same MCO;
- Correcting a clerical error that caused you to be enrolled with the wrong MCO;
- Traveling an unreasonable distance for primary health care;
- Problems getting the services you need in the Molina Healthcare network; or
- Experiencing poor quality of care by Molina Healthcare providers.

You must call or send a written request to HSD to switch from Molina Healthcare. HSD will review the request and give you a

written response no later than the first (1st) day of the second (2nd) month following the month in which you asked for the change. If HSD does not respond in time, then the request is approved. For help with the dis-enrollment process you can call Customer Support Center. If your request is approved, Molina Healthcare will work with you to transfer your care to the new MCO.

Send your written request to:

HSD Client Services Bureau

P.O. Box 2348

Santa Fe, NM 87504-2348

Or call: (888) 997-2583 toll free



Your request must have the following information:

- The name of the MCO you want to switch to;
- Your name, Social Security number and identification number;
- Your full mailing address and telephone number;
- The reason for the change – if it involves a doctor, you need to give the doctor's name and telephone number; and
- Your signature.

HSD will send a letter to you if the MCO switch is denied. The letter will tell you about your right to appeal the decision or to ask for a Fair Hearing.

Renewing Your Coverage

Every twelve (12) months you will need to renew your eligibility. If you have questions, you can call Customer Support Center. You can also call your local Human Services Department Income Support Division office.

Losing Your Coverage

You will no longer be covered by Molina Healthcare if you:

- Lose your Medicaid eligibility;
- Give false information on your enrollment form; or
- Move out of the state.

If you lose your Medicaid benefits while you are getting care, Molina Healthcare can tell you about other services in your area.

We can also tell you about other programs in your area. These programs may help you to keep getting care. If you lose your coverage, you should call your local Human Services Department Income Support Division office. They can look at your case. Remember to visit your local Human Services Department Income Support Division office when you need to recertify for benefits. If you lose your coverage and receive services, you will be financially responsible for those services.

Other Insurance Coverage

Call Customer Support Center to tell us if you have:

- Medical insurance through your workplace;
- Been hurt at work;
- A worker's injury claim;
- A car accident;
- Filed a medical malpractice lawsuit;
- A personal injury claim; or
- Other coverage or insurance.

This information is important to have. It will help us make sure we manage your services right.

Out-of-Pocket Costs

Working Disabled Individual (WDI) - The total amount of co-payments you will have to pay each year is limited.

- If your earned and unearned income is below one-hundred (100%) percent of the Federal Poverty Level, the highest amount of co-payments you will have to pay is \$600; or
- If your earned and unearned income is between one-hundred (100%) and two-hundred fifty (250%) percent of the Federal Poverty Level, the highest amount of co-payments you will have to pay is \$1500.

You will need to keep the receipts for the co-payments you have paid. Once you have paid the highest amount listed above, you must tell the Medical Assistance Division. You will need to continue to make co-payments until they tell you when you can stop making co-payments. You will not have to make co-payments for the rest of that calendar year.

Children's Health Insurance Program Reauthorization Act (CHIPRA) - The total amount of copayments you will have to pay each year is limited.

If your family income is between one-hundred eighty-five (185%) and two-hundred (200%) percent of the Federal Poverty Level, the highest amount of co-payments you will pay is three (3%) percent of your family income;

- If your family income is between two-hundred one (201%) and two hundred fifteen (215%) percent of the Federal Poverty Level, the highest amount of copayments you will pay is four (4%) percent of your family income; or
- If your family income is between two-hundred sixteen (216%) and two-hundred thirty-five (235%) percent of the Federal Poverty Level, the highest amount of co-payments you will pay is five (5%) percent of your family income.

You will need to keep the receipts for the co-payments you have paid. Once you have paid the highest amount listed above, you must tell the Medical Assistance Division. You will need to continue to make co-payments until they tell you when you can stop making co-payments. You will not have to make co-payments for the rest of that calendar year.

MEMBER ADVISORY BOARD

Molina Healthcare hosts centrally located meetings with the Member Advisory Board (MAB) every three (3) months. The MAB consists of Members representing all Centennial Care populations including family members, providers, advocacy groups, and other community-based organizations.

Molina Healthcare also hosts two (2) additional statewide MAB meetings each Contract year that focus on Member issues to help ensure that Member issues and concerns are heard and addressed. The MAB advises Molina Healthcare on issues concerning service delivery and quality of all covered services (e.g., behavioral

health, physical health and long-term care), Member rights and responsibilities, resolution of Member Grievances and Appeals and the needs of groups represented by MAB members as they pertain to Medicaid.

Molina Healthcare uses the input it receives from its MAB Members to evaluate how well the plan is serving and meeting the needs of its Members. As appropriate, Molina Healthcare accepts the MAB's recommendations to enhance a process, and/or to correct or act upon any opportunity for improvement.

All Molina Healthcare Members are encouraged to take part in the MAB. For more information or to join the MAB, please call Customer Support Center. You may also call Customer Support Center if you have ideas for the MAB to consider.

NATIVE AMERICAN MEMBER ADVISORY BOARD

Molina Healthcare hosts meetings with the Native American Member Advisory Board. At a minimum, such meetings will occur quarterly. Native American Advisory Board members shall serve to advise Molina Healthcare on any issues pertaining to Native Americans including, but not limited to, issues concerning operations, service delivery and quality of all Covered Services (e.g., Behavioral Health, physical health and Long-Term Care), Member rights and responsibilities, the resolution of Member Grievances and Appeals, and Claims processing and reimbursement issues.

Molina Healthcare Members are encouraged to take part in the MAB meetings. Call Customer Support Center if you want to join. You can also call Customer Support Center if you have ideas for the MAB to consider.

ON-LINE SERVICES

www.MyMolina.com

Molina Healthcare has an on-line service you can use. It is called a Web Portal. All members can use it. There is no charge. Molina Healthcare's web-based ePortal is a secure site. It has real-time information. You can use it twenty-four (24) hours a day, seven (7) days a week.



MyMolina.com Registration

Follow these easy steps to register your account.

Step 1: Member Information

- Select Molina ID# by clicking on the radio button, you will need to enter:
 - ▶ Date of birth – mm/dd/yyyy
 - ▶ Zipcode
- Select SSN by clicking on the radio button, you will need to enter:
 - ▶ Last Name
 - ▶ First Name
 - ▶ Date of birth – mm/dd/yyyy
 - ▶ Zipcode

Step 2: Enter email address

- Confirm email address

Step 3: User Name and Password

- Create Username
- Enter Password
- Confirm Password

There is a video tour if you want to see more. This video tour will help you understand how to register. If you have question call Member Services. Member Services will help you register and answer questions you have.

PRIVACY AND PROTECTED HEALTH INFORMATION (PHI)

Your Privacy

Your privacy is important to us. We respect and protect your privacy. Molina Healthcare uses and shares your information to provide you with health benefits. Molina Healthcare wants to let you know how we may share or use your information.

“**PHI**” means “*protected health information*.” PHI is your health information that includes your name, member number or other things that can be used to identify you, and is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share your PHI?

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

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

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

What are your privacy rights?

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

How does Molina Healthcare protect your PHI?

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

- Has policies and rules to protect PHI;
- Limits who may see PHI. Only Molina Healthcare staff with a need to know may use and share PHI;
- Staff is trained on how to protect and secure PHI;

- Staff must agree in writing to follow the rules and policies that protect and secure PHI; and
- Secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

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

- Call or write Molina Healthcare and file a complaint; or
- File a complaint with the U.S. Department of Health and Human Services.

We will not hold anything against you. Your action will not change your health benefits in any way.

The above is only a summary. Our ***Notice of Privacy Practices*** has more details about how we use and share our members' PHI. Our ***Notice of Privacy Practices*** is included in your New Member packet and is on our web site. You can call Customer Support Center and ask for a copy of our ***Notice of Privacy Practices***.

COMPLAINTS, APPEALS AND GRIEVANCES

When you may have to pay for other charges

There may be times when Molina Healthcare will not pay a bill from a practitioner/provider. This may be because the service is not covered. Or maybe the practitioner/provider is not contracted with Molina Healthcare.

If Molina Healthcare does not pay the bill, the practitioner/provider will send the bill to you. They will send the bill to you if you:

- Did not show your Molina Healthcare ID card when you got the service;
- Saw a practitioner/provider who is not contracted with Molina Healthcare and the practitioner/provider did not get an approval; or
- Agreed in writing to pay for the service before the service was provided, this includes going to the Emergency Room for something that is not an emergency.

If you think the practitioner/provider sent the bill to you by mistake,

you have thirty (30) calendar days to file a complaint (also known as a grievance). You can file your complaint with the Molina Healthcare Appeals Department. You can call or write to file a complaint.

Molina Healthcare of New Mexico, Inc.

Attn: Appeals Department

P.O. Box 3887

Albuquerque, NM 87190-9859

Albuquerque: (505) 342-4681 or

Toll free: (800) 580-2811



To learn more about how to file a complaint or appeal, please see these sections of your Member Handbook:

- How Complaints and Appeals work;
- How to File a Complaint, Appeal or Expedited Appeal; or
- How to Request an State Fair Hearing.

How Complaints and Appeals Work

You have a right to file a complaint or appeal. You can do this using the Molina Healthcare complaint/appeal process.

A complaint, also called a grievance, is an oral or written statement you can make saying you are unhappy about a part of Molina Healthcare or its operations.

An appeal is a written request. The appeal can be requested orally, but must be followed-up in writing within thirteen (13) calendar days. If the written and signed appeal is not received within thirteen (13) calendar days, the appeal will be considered to have been withdrawn. Molina can help you with the written appeal if you need help. Call either of the numbers shown above to ask for help. An appeal request asks for a review or reconsideration of a Molina Healthcare action. This can be related to limiting, discontinuing or denying approval for a service you asked for.



An expedited appeal is for certain situations. These are situations that can harm your health. If we decide the normal review time might harm your life or health, an expedited review will take

place. This happens within seventy-two (72) hours of receiving the request.

How to File a Complaint, Appeal or Expedited Appeal

You can call or fax or write to file a complaint or appeal.

You can call the complaint and appeal telephone numbers. You can call them twenty-four (24) hours a day, seven (7) days a week. Remember: you must follow an oral appeal request with a written appeal request within thirteen (13) calendar days.

In Albuquerque: (505) 342-4663

Toll free: (800) 723-7762

Fax: (505) 342-0583 Attn: Appeals Department

Molina Healthcare of New Mexico, Inc.

Attn: Appeals Department

P.O. Box 3887

Albuquerque, NM 87190-9859

Who Can File a Complaint or Appeal?

You can file a complaint or appeal. Or a complaint or appeal can be filed by:

- A legal guardian if you are incapacitated;
- Someone of your choice if you approve in writing; or
- Your practitioner/provider if you approve in writing.

You can speak for yourself in a complaint, appeal or Fair Hearing. You have the right to have another person speak for you. You have the right to have legal counsel. You must pay for the cost of being represented. Molina Healthcare will let you, your representative, or your estate representative be parties to an appeal.

Filing a complaint or appeal will not change the way you are treated. Asking for a Fair Hearing will not change the way Molina Healthcare treats you. It will not change how Molina Healthcare's network practitioners/providers or the Human Services Department (HSD) treats you.

Everything about your complaint or appeal is private. We do not give out your information about a complaint. We cannot do this without your approval in writing unless we are required by law. The filing limit for filing a complaint is thirty (30) calendar days from the date of the dissatisfaction. An appeal must be filed within ninety (90) calendar days. This is from the date of the occurrence.

Molina Healthcare wants to give you the best care possible. Call Customer Support Center if you are having problems. We want to fix the problem. Customer Support Center can help if you need help in another language. We will help you with the translation service.

The Appeals Department can help you through the complaint or appeal process. Let us know if you need help making a written request. We try to fix issues as fast as we can. If the issue cannot be taken care of on the same day we get it; a formal grievance or appeal process will take place. There will be a careful investigation. The filing limit to ask for a grievance is thirty (30) calendar days and for an appeal the filing limit is ninety (90) calendar days. Both are from the date of the occurrence.

Molina Healthcare will give you written notice that the complaint or appeal was received. When we get the complaint or appeal, the notice will be sent within five (5) working days after we get the request. The notice will have the timeframe we expect to resolve the complaint or appeal. It will have information on the complaint and appeal process. You and/or your representative can look at the case file before and during the complaint/appeal process. This includes medical records and other documents used during the complaint/appeal process that are not private or privileged information.

A health care professional with suitable clinical experience will take part in the review of medically related complaints or appeals. Formal complaints or appeals are normally resolved within thirty (30) calendar days. We will ask for more time if it is needed. An extension of up to fourteen (14) calendar days can be given if you ask for it. An extension can be given by the Human Services Department (HSD) to Molina Healthcare. We will tell you if there is a delay.

A written decision will be made for all formal complaint and appeal requests. The written response for a **complaint** will have the:

- Reason for the complaint;
- Information used in the investigation;
- Findings and conclusions based on the investigation; and
- Outcome of the complaint.

The written response for an **appeal** will have the:

- Reason for the appeal;
- Result of the appeal resolution; and
- Date the appeal was completed.

If the appeal results in a continued denial, the written notice will have the:

- Reason for the action being taken by Molina Healthcare;
- Specific references and citations supporting the decision as taken from the Medical Assistance Division (MAD) and/or Molina Healthcare policies and procedures;
- Information on your right to ask for a Fair Hearing of an appeal denial within thirty (30) calendar days of the final decision. You are not responsible for the cost of Fair Hearing through the State;
- Right to ask for benefits while the hearing is pending. We will let you know how to ask for this; and
- Information that you may have to pay for the cost of continuing benefits. This is if the hearing decision upholds Molina Healthcare's denial.

How to Request State Fair Hearing, After first exhausting Molina Healthcare's Grievance and Appeal process.

You have a right to ask for a Fair Hearing. You can do this when Molina Healthcare makes a decision to modify, change or terminate your benefits. You can do this when Molina Healthcare makes a decision to suspend, reduce or deny a requested service or good.. You do not have to pay for the cost of an Administrative Hearing. You and/or your spokesperson will work with Molina Healthcare in the Hearing.

You have a right to ask for a Fair Hearing to appeal a Molina Healthcare decision, after you have exhausted Molina Healthcare's internal Grievance/Appeal process.. You ask for the appeal to the HSD Hearings Bureau. You have to do this within thirty (30) calendar days of the final Molina Healthcare decision. You can contact HSD Fair by writing or calling:

**New Mexico Human Services Department
Fair Hearings Bureau
P.O. Box 2348
Santa Fe, NM 87504-2348
In Santa Fe: (505) 476-6213
Toll free:(800) 432-6217, then press #6**

If you ask for a Fair Hearing directly to Molina Healthcare, we will send it to HSD. Molina Healthcare cannot ask for a Fair Hearing for you. Your practitioner/provider cannot ask for a Fair Hearing for you. You must give your approval in writing.

Under some circumstances, we will not stop your services until after a ruling from the hearing. Your request for a Fair Hearing must be received by HSD within thirty (30) calendar days from Molina Healthcare's final decision.

This does not require Molina Healthcare to start any treatment or services. This does not require Molina Healthcare to increase the level of any current treatment or services. You may have to pay the cost of treatment or services you get while the Fair Hearing is pending. You will have to pay the cost of services you get if the denial is upheld at the hearing.

If the request for a Fair Hearing is not received within thirty (30) calendar days, Molina Healthcare may stop providing treatment or services related to the appeal.

FRAUD, WASTE AND ABUSE

Health care fraud, waste, and abuse are against the law. Fraud, waste, and abuse can make taxes go up. They can cause quality of care issues. Molina Healthcare works with state and federal agencies to detect, prevent, investigate, and report these kinds of crimes.

State and federal laws require Molina Healthcare to report fraud, waste and abuse. Cases are sent to the government and/or law enforcement for investigation.

What is Fraud?

Fraud is an unfair or unlawful act. Fraud is done on purpose to get something of worth.

What is Waste?

Health care spending that is not necessary for appropriate quality of care. Quality waste includes overuse, underuse, and ineffective use. Inefficiency waste includes doing more than what is needed. It can cause delays, and result in processes that are not needed.

What is Abuse?

Abuse happens when things are not done in line with good financial, business or medical practices. This can result in unnecessary costs and can result in payment for services that are not medically necessary. It can result in services that fail to meet professionally recognized standards for health care.

Who commits Fraud, Waste and Abuse?

Anyone can commit fraud, waste or abuse. This can include providers and members.

Provider Fraud, Waste and Abuse examples

- Altering claims, electronic forms and/or medical records in order to get a higher payment;
- Asking for, offering, or getting a kickback, bribe or rebate;
- Balance billing happens when a provider bills a member for all charges not paid for by the health plan;
- Billing a procedure that does not match the diagnosis or problem;

- Billing for services that did not happen;
- Billing for services using a provider's name that did not provide care;
- Billing the wrong place of service in order to get payment or get a higher payment;
- False coding in order to get payment or get a higher payment;
- Charging members for medication samples;
- Having members come in for office visits more often than is needed;
- Not billing coding modifiers the right way in order to get payment or get a higher payment;
- Questionable prescription practices;
- Questionable transportation services;
- Unbundling services in order to get more payment. This involves splitting a procedure into parts and charging for each part rather than using a single code;
- Underutilization means failing to provide services that are medically necessary;
- Upcoding happens when a provider does not bill the right code for the service and uses a code for a like services that costs more; and
- Waiving co-payments.

Member Fraud, Waste and Abuse Examples

- Abusing transportation benefits (e.g. using ambulance services for nonemergencies);
- Doctor shopping in order to get services that are not needed; (e.g. equipment or medication)
- Drug seeking behavior;
- Drug trafficking;
- Forgery;
- Giving false information;
- Identity theft;
- Not paying co-payments;
- Not giving information to Molina Healthcare about other insurance coverage;
- Theft; and
- Using someone else's medical card.

Reporting Fraud, Waste and Abuse

Anyone with information about possible fraud, waste, and abuse can make a referral. Referrals are sent to Compliance. You can make a referral without giving your name. Information reported to Compliance will remain confidential to the extent possible as allowed by law.

Molina Healthcare does not allow or tolerate retaliation against those, who in good faith, report potential fraud, waste and abuse to Molina. You can report suspicious activity. You can do this by contacting the Molina Healthcare AlertLine at:

Toll free, 866-606-3889

Or

Complete a report online at:

<https://molinahealthcare.alertline.com/gcs/welcome>

Give us as much information as you can when making a referral.

We need to know:

- Who is the suspect?
- What is the suspect's name?
- When did the possible fraud, waste and abuse happen?
- Where did the possible fraud, waste and abuse happen?
- Why do you think the possible fraud, waste and abuse happened?
- How did the possible fraud, waste and abuse happen?

The more details you can give Molina, the better. This improves the chances the issue will be successfully reviewed and resolved.

You can also report fraud, waste and abuse to:

Medical Assistance Division

Quality Assurance Bureau P.O. Box 2348

Santa Fe, NM 87504-2348

NMMedicaidFraud@state.nm.us

Toll free: (888) 997-2583 In Santa Fe: (505) 827-3100

Medicaid Fraud Control unit

111 Lomas NW, Suite 300

Albuquerque, NM 87102

Toll free: (800) 678-1508

In Albuquerque: (505) 222-9000

New Mexico Human Services Department

Office of Inspector General

Toll free: (800) 228-4802

In Albuquerque: (505) 827-8141

HSDOIGFraud@state.nm.us

DEFINITIONS

Abuse: Abuse happens when things are not done in line with good financial, business or medical practices. This can result in unnecessary costs and can result in payment for services that are not medically necessary. It can result in services that fail to meet professionally recognized standards for health care.

Advance Directive: Adult members can make choices about their medical care. An advance directive form tells how the member wants to be cared for while sick or in an emergency.

Appeal: An oral or written request for review or reconsideration of a Molina Healthcare action. This request can be for limiting or denying approval for a requested service. The request can be for not paying for a service.

Benefit Period: The period of time you have health insurance.

Benefits (also referred to as Services): The health care and other services you can get as a member of Molina Healthcare. This is defined by the State of New Mexico.

Client: A person that is Medicaid eligible but not yet enrolled in Centennial Care.

Complaint (also known as a Grievance): An oral or written statement about any aspect of Molina Healthcare or its operations. Complaints can be voiced or filed by a:

1. Member.
2. Legal guardian for an incapacitated member.
3. Member's authorized representative as selected in writing.
4. Practitioner/provider acting on behalf of the member with the member's written consent.

Co-Payment: The member's share of costs for covered services. The amount is normally paid to the attending provider at the time care is given. There are specific co-payment amounts that apply to covered services. These are listed in the Member Handbook.

Covered Services (Benefits): The benefits offered in the Centennial Care Program. The benefits are offered by the State of New Mexico Human Services Department.

Durable Medical Equipment (DME) and Medical Supplies:

Equipment that is:

1. Primarily and commonly used to serve a medical purpose.
2. Designed for repeated use.

This equipment is needed to give mechanical substitution or help to the member. It will help prevent further worsening of the member's medical condition. It is not ordinarily useful to a person without illness or injury. DME includes items such as wheelchairs, hospital beds, oxygen and oxygen supplies.

Emergency Health Services: An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

Family Planning: Health education that helps you make the right choices about birth control.

Fraud: Fraud is an unfair or unlawful act. Fraud is done on purpose to get something of worth.

Grievance (also known as a Complaint): See Complaint

HIPAA: Refers to the "Health Insurance Portability and Accountability Act." A set of rules that helps keep patient health information secure and private.

Home Health Care: Medical services and care that are given in the home.

Hospice: Care for a member who might not live more than six (6) months.

Hospital: An eligible, licensed and approved acute care facility.

Human Services Department (HSD): The official department in New Mexico in charge of overseeing the Medicaid Program. HSD may also indicate the department's designee (Molina Healthcare).

Identification Card (ID): A card issued to a member. The card is issued when approval is given by HSD. The card has important information about your Centennial Care coverage.

Immunizations: These help protect you from disease and illness.

I/T/U: Indian Health Services facilities/Tribal Facilities/Urban clinics

Managed Care Organization: A company that gives or arranges basic health care services to Members.

Medicaid Birthing Options Program: A program for pregnant women who are eligible for Medicaid. This program is provided by the New Mexico Human Services Department.

Medical Director: The physician employed by Molina Healthcare to serve as the Medical Director of the Plan.

Medically Necessary: (a) Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

- (i) are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;
- (ii) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual;
- (iii) are provided within professionally accepted standards of practice and national guidelines; and
- (iv) are required to meet the physical and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.

Member: A person enrolled in the Centennial Care Program (Molina Healthcare).

Member Responsibilities: Your duties as a member.

Member Rights: Your rights as a member.

Molina Healthcare: Molina Healthcare of New Mexico, Inc. A corporation organized under the laws of the State of New Mexico.

Network Provider: A practitioner/provider that works with Molina Healthcare. They give medical care to members.

Non-Participating Provider: A practitioner/provider who does not have a contract with Molina Healthcare. If you get services from a Non-Participating Provider without Molina Healthcare's authorization, you will have to pay the bill.

Non-Covered Services (Benefits): Services that are not covered. This is decided by the State of New Mexico. Molina Healthcare will not pay for services that are not covered. If you get a non-covered service without Molina Healthcare's authorization, you will have to pay the bill.

Out-of-Pocket: The amount a member may have to pay a practitioner/provider for a service. This amount is separate from the payment Molina Healthcare may pay.

Practitioner: A licensed clinician contracted with Molina Healthcare.

Preventive Care: Health services to help avoid illness, disease and serious injury. These services can include immunizations, screening or other health maintenance programs.

Primary Care Practitioner (PCP): The practitioner you have picked from the list that was sent to you.

Prior Approval (Authorization): The process to get an approval before a member can get certain covered services.

Protected Health Information (PHI): PHI is your health information. It includes your name, member number or other things that can be used to identify you. PHI is used or shared by Molina Healthcare.

Referral: When your PCP sends you to see another practitioner/provider for care.

Second Opinion: When you or your PCP ask another practitioner's/provider's opinion about your illness, injury or condition.

Urgent Care Services: Medical health services needed to treat an unforeseen illness or injury. The illness or injury is less serious than an emergency but needs prompt treatment to prevent serious decline of the member's health.

Waste: Health care spending that is not necessary for appropriate quality of care. Quality waste includes overuse, underuse, and ineffective use. Inefficiency waste includes doing more than what is needed. It can cause delays and result in processes that are not needed.

Well-Child Check-ups: Well-Child Health Checks are good for babies, children and teens to prevent illness. Care your child's PCP gives at the visit can help keep them from getting sick.

Centennial Care Alternative Benefit Plan Supplement

This addition, which is intended to be used with your Centennial Care Member Handbook, and other Member information are on our website at www.MolinaHealthcare.com. This addition has helpful information. This addition tells you about the benefits and services you can get. It will explain how the ABP works. If you have questions about the ABP, you can call Member Services. We can answer your questions.

Please read this addition. This addition and our Centennial Care Member Handbook tell you how to use your benefits. It will help you know what your benefits are. Do not wait until you have an emergency. Call us if you have questions. Let us know if you need help understanding this addition or your Member Handbook. Keep this addition and your Member Handbook where you can find them.

The ABP is a part of the New Mexico Medicaid program known as Centennial Care. The ABP is designed to provide medical insurance coverage to adults up to 138% of the Federal Poverty Level (FPL). The benefits, in some cases, are not the same as Centennial Care. Be sure to read this supplement to know what benefits are covered under the ABP.

ABP recipients will have their medical condition evaluated by Molina Healthcare. If it is determined that you meet the qualifying conditions, you may choose to become an “ABP Exempt” recipient. If you choose to become APB Exempt, you coverage will change from the ABP benefit package, to the full Medicaid (Centennial Care) benefit package. Please call Member Services for full details regarding ABP Exempt qualifications.

Benefits and Services

Some of the services that ABP covers:

- Autism Spectrum Disorder (benefits provided up to age 22);
- Bariatric Surgery (limits apply);
- Behavioral Health and substance abuse services;

- Cancer trials, chemotherapy, IV infusions and reconstructive surgery;
- Cardiac Rehabilitation (limited to 36 hours per year);
- Chemotherapy;
- Dental services;
- Diabetes treatment including diabetic shoes;
- Dialysis;
- Health Management;
- Durable Medical Equipment (limits apply);
- Educational Materials and Counseling for a healthy lifestyle;
- Emergency services (including emergency room visits and psychiatric emergency services);
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for individuals age 19 and 20;
- Eye exams – medically necessary and treatment related to treatment and testing of eye diseases only;
- Eye exams – routine (limits apply);
- Family planning, sterilization, pregnancy termination and contraceptives;
- Genetic testing such as BRCA1 and BRCA2 used to determine appropriate treatment (not covered for random genetic screening);
- Glasses and contact lenses (limits apply);
- Hearing testing or screening as part of a routine health exam (hearing aids are not covered);
- Home Health Services (limited to 100 visits per year. One (1) visit may not exceed four (4) hours);
- Hospice services (limited to \$10,000 lifetime benefit);
- Hospital services including, inpatient, outpatient, urgent care and emergency room;
- Immunizations and age appropriate testing such as mammography, colorectal cancer screenings, pap smears and PSA tests;
- Inhalation therapy;
- IV Infusions;
- Laboratory services, including diagnostic testing and other age appropriate tests;
- Mammography, colorectal cancer screenings, pap smears, PSA tests and other age appropriate tests;
- Medical supplies: diabetic supplies only;
- Medication assisted treatment for opioid dependence;

- Nutritional Counseling;
- OB/GYN, prenatal care, deliveries and midwives;
- Orthotics (limits apply);
- Physician and most practitioner services and visits, including maternity service, surgeries, anesthesia, etc.;
- Podiatry (limits apply);
- Prescription drugs (some restrictions apply);
- Preventive care and annual physicals (see list of Preventive services below);
- Prosthetics;
- Pulmonary rehabilitation;
- Radiology, including diagnostic imaging and radiation therapy, mammography and other age appropriate imaging;
- Reconstructive surgery;
- Rehabilitation inpatient hospitalization: step-down lower level of care from an acute care hospital for not more than 14 days;
- Reproductive health services;
- Skilled nursing;
- Sleep studies (limits apply);
- Telemedicine;
- Tobacco cessation counseling;
- Transplant services (limited to \$1,000,000 per lifetime);
- Transportation services, emergency and non-emergency. Includes air and ground ambulance, taxi and handivan; and
- Urgent care services.

Preventive Care Services:

The following preventative services, as recommended by the federal government*, are covered under ABP (some limits apply, please call Member Services toll free at (800) 580-2811 for more information:

- Abdominal aortic aneurysm screening: men;
- Alcohol misuse: screening and counseling;
- Anemia screening: pregnant women;
- Aspirin to prevent cardiovascular disease: men and women;
- Bacteriuria screening: pregnant women;
- Blood pressure screening in adults;
- Breast Cancer Susceptibility Gene (BRCA) screening;
- Breast cancer preventive medication;
- Breast cancer screening;
- Breastfeeding counseling;

- Cervical cancer screening;
- Chlamydial infection screening: pregnant and non-pregnant women;
- Cholesterol abnormalities screening: men and women;
- Colorectal cancer screening;
- Depression screening: adults;
- Diabetes screening;
- Falls prevention in older adults: exercise, physical therapy and vitamin D;
- Folic acid supplementation;
- Gonorrhea screening: women;
- Healthy diet counseling;
- Hepatitis B screening: pregnant women;
- Hepatitis C virus infection screening: adults;
- HIV screening: non-pregnant adolescents and adults;
- HIV screening: pregnant women;
- Intimate partner violence screening: women of childbearing age;
- Obesity screening and counseling: adults;
- Osteoporosis screening: women;
- Rh incompatibility screening: first pregnancy visit;
- Rh incompatibility screening: 24-28 weeks gestation;
- Sexually transmitted infections counseling;
- Skin cancer behavioral counseling;
- Syphilis screening: non-pregnant and pregnant women;
- Tobacco use counseling and interventions: non-pregnant adults; and Tobacco use counseling: pregnant women.

**United States Preventive Services Task Force (USPSTF)*

Services requiring Prior Authorization

The services listed below require prior authorization from Molina Healthcare. Please call our Member Services department toll free at (800) 580-2811 for more information regarding prior authorizations:

- Behavioral Health: mental health, alcohol and chemical dependency Services;
- Bariatric surgery;
- CPAP machine;
- Cosmetic, plastic and reconstructive procedures;
- Dental general anesthesia;

- Dialysis (notification only);
- Adult diapers and other incontinence products (non-Medicare covered);
- Durable Medical Equipment/medical supplies/orthotics/prosthetics;
- Experimental/Investigational procedures;
- Genetic counseling and testing;
- Home Health Care (after three (3) skilled nursing visits);
- Home infusion;
- Outpatient hospice and palliative care (notification only);
- Imaging: CT, MRI, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms Intimal Medial Thickness Testing, 3D Imaging;
- Inpatient Admissions: Acute Hospital, Skilled Nursing facilities, Rehabilitation, Long-Term Acute Care facilities, Hospice (requires notification only);
- Long-Term Care Services (per state benefit);
- Neuropsychological and psychological testing and therapy;
- Non-Participating provider/facility services;
- Nutritional supplements and enteral formulas;
- Occupational Therapy (outpatient and home settings);
- Office-based podiatry surgical procedures;
- Outpatient hospital/ambulatory surgery center procedures;
- Pain management procedures;
- Physical Therapy (outpatient and home settings);
- Pregnancy and delivery (notification only);
- Rehabilitation; cardiac, pulmonary, Comprehensive Outpatient Rehabilitation Facility (CORF) services (for Medicare only);
- Sleep studies;
- Specialty pharmacy drugs (oral and injectable);
- Speech Therapy (outpatient and home settings);
- Transplant evaluation and services, including solid organ and bone marrow (except cornea transplants);
- Transportation (non-emergent ground and air ambulance);
- Unlisted Procedures;
- Weight Watchers® meetings; and
- Wound therapy, including wound vacs and hyperbaric wound therapy.

Other services that may be covered under ABP

Here are some services that have limitations to coverage under ABP. Please call Member Services toll free at (800) 580-2811 for more information:

SERVICE:

- Bariatric surgery;
- Cardiac rehabilitation;
- Chiropractic services;
- Drug items that do not require a prescription (over the counter);
- Hearing aids;
- Home Health care;
- Hospice;
- Medical foods;
- Medical supplies;
- Pulmonary rehabilitation;
- Rehabilitation and habilitation;
- Physical therapy;
- Occupational therapy;
- Speech and language pathology;
- Rehabilitation hospitalization;
- Sleep studies; and
- Transplants.

Some services that are not covered under ABP:

- The following services are not covered. If you get these services, you will have to pay the bill.
- Acupuncture;
- Inpatient rehabilitative facilities;
- Infertility treatment;
- Naprapathy;
- Newborn child care;
- Special medical foods; and
- Temporomandibular joint (TMJ) and craniomandibular joint (CMJ) treatment.

ABP Recipient Cost Sharing

The table below shows what you will have to pay for specific services:

ABP - ABP COPAYMENTS APPLIES ONLY TO ABP RECIPIENTS WHO ARE 101% - 138% FPL	
<u>Service/Cost Share</u>	<u>Exemptions</u>
<p><u>PHARMACY COPAYMENT (101% - 138% FPL):</u> \$3 per drug item See exemptions in the next column, including exemptions for family planning, preventive services, and prenatal drug items and some Behavioral Health drugs.</p> <p>\$8 For a brand name drug when there is a less expensive therapeutically equivalent drug on the Molina Healthcare prescription drug list. Unless your doctor provides evidence that the alternative drug on the Molina Healthcare prescription drug list will be less effective or have greater adverse reactions.</p> <p><u>PHARMACY COPAYMENT (up to and including 100% FPL):</u> \$ 0 for drugs on the Molina Healthcare prescription drug list.</p> <p>\$3 For a brand name drug when there is a less expensive therapeutically equivalent drug on the Molina Healthcare prescription drug list. Unless your doctor provides evidence that the alternative drug on the Molina Healthcare prescription drug list will be less effective or have greater adverse reactions.</p> <p><u>NON-EMERGENCY USE OF THE EMERGENCY ROOM</u> \$ 8 For non-emergent use of ER (up to and including 150% FPL)</p> <p>\$50 For non-emergent use of ER (greater than 150% FPL)</p> <p><u>PRACTITIONER SERVICES</u> <u>COPAYMENTS:</u> \$ 0 Outpatient Visit to physician or other practitioner, dental visit, rehabilitative or habilitative therapy session. (up to and including 100% FPL).</p> <p>\$8 Outpatient visit to physician or other practitioner, dental visit, rehabilitative or habilitative therapy session. (101% to 138% FPL)</p>	<p>EXEMPTIONS from copayments for ABP</p> <ol style="list-style-type: none"> 1. Native Americans 2. Services rendered by Indian Health Services (IHS), Tribal 638 facility, or Urban Indian Facility 3. Emergency services , see notes below.* 4. Family planning services, including drugs, procedures, supplies, and devices 5. Hospice patients 6. Medicare Cross Over claims including claims from Medicare Advantage Plans 7. Pregnant women 8. Prenatal & postpartum care and deliveries, and prenatal drug items 9. Mental health (Behavioral Health) and substance abuse services, including psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.) 10. All preventive services 11. Provider preventable conditions 12. When the maximum family out of pocket expense has been reached.

<p>This copayment applies in places of service such as offices, outpatient hospitals (other than emergency rooms), clinics, and urgent care centers. It is applied to the professional service (the doctors charges), not to any facility charge.</p> <p>Practitioner services copayments do not apply to emergency room facility or emergency room professional charges because of the exemption for emergency services (See below).</p> <p><u>HOSPITAL COPAYMENTS</u></p> <p>\$0 inpatient admission - (up to and including 100% FPL).</p> <p>\$ 25 inpatient admission – This copayment does not apply if you are being transferred from another hospital or if you are admitted through the emergency room (101% to 138% FPL). When the copayment is applied to an inpatient service, the copayment is always applied to the hospital's facility charge, not the doctor's charge.</p>	
<ul style="list-style-type: none"> - <u>Emergency Services Exemption for Above ABP Copayments</u> - The ABP copayments do not apply when treatment is for an “exempt emergency service” as described in the Social Security Act and CFR. - These provisions clearly exempt all medically necessary emergency room services from copays. However, there may be additional situations that qualify as emergency services. - For additional information on this provision, see note below. 	
<p>Exempt emergency services (federal definitions): <i>Emergency medical condition</i> means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:</p> <ol style="list-style-type: none"> (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part. <p><i>Emergency services</i> means covered inpatient and outpatient services that are as follows:</p> <ol style="list-style-type: none"> (1) Furnished by a provider that is qualified to furnish these services under this title. (2) Needed to evaluate or stabilize an emergency medical condition. 	