



2018 PROVIDER POLICIES AND PROCEDURES MANUAL

Molina Healthcare of Utah, Inc.

Molina Healthcare of Idaho

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Policy

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks	Policy No. MHU-PS-7
Title: MHU – VP Network Management	Policy Title: Provider Satisfaction
Signature:	Department Name: Provider Services
Approval Date:	Effective Date: 10/1/03
<i>If Required:</i>	Reviewed and Revised Date: 2/17, ID 8/17,8/18
Approver Name:	Review Only Date: 1/04, 2/06, 4/07, 2/10, 2/12, 11/12, 6/13, 3/14, 2/16
Title:	Supersedes and replaces:
Signature:	N/A
Approval Date:	

Line of Business: <i>(Please click all that apply)</i>		
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN
<input checked="" type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input checked="" type="checkbox"/> Health Insurance Marketplace	<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)
<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP	<input type="checkbox"/> ID Medicaid Plus

References (s): *(Identify if this policy references another policy or contract requirement.)*

N/A

Departments identified in the policy:

Provider Services

Oversight Committee:

Member Provider Satisfaction Committee (MPSC)

I. PURPOSE

To define a consistent policy for measuring provider satisfaction.

II. POLICY

MHU is committed to creating and maintaining a strong partnership with the network of contracted Practitioners and Providers in regards to service and the delivery of high quality, timely and appropriate health care.

III. DEFINITIONS

N/A

SLT Signature *(if expedited):* _____ **Date:** _____

Procedure

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks	Procedure Title: Provider Satisfaction
Title: MHU – VP of Network Management	Policy No. Reference: MHU-PS-7
Signature:	Policy Title Reference: Provider Satisfaction
Approval Date:	Department Name: Provider Services
<i>If Required:</i>	Effective Date: 10/1/03
Approver Name:	Reviewed and Revised Date: 2/17, ID 8/17, ID 8/18
Title:	Review Only Date: 1/04, 2/06, 4/07, 2/10, 2/12, 11/12, 6/13, 3/14, 2/16
Signature:	Supersedes and replaces:
Approval Date:	N/A

Line of business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid
<input checked="" type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input checked="" type="checkbox"/> Health Insurance Marketplace
<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP
<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN <input checked="" type="checkbox"/> ID Medicaid Plus

Description of process and procedure/service:

A. Provider Satisfaction measurement and improvement activities include, but are not limited to:

1. An Annual Provider Satisfaction Survey
2. Analysis of Provider Grievance and Appeal data
3. Claims data

B. MHU shall analyze the results of the Provider Satisfaction activities; MHU identifies opportunities for improvement, sets priorities and decides which opportunities to pursue.

C. MHU is committed to resolving Provider related issues of dissatisfaction as soon as they occur.

D. At least annually, MHU will analyze the results from the Provider Satisfaction Survey and other satisfaction related data to identify areas of improvement for use in Service QIA's as appropriate and as part of the organizations Quality Improvement process.

E. The results of these activities will be available to Practitioners and Providers as appropriate utilizing the following methods:

1. Online at www.molinahealthcare.com

2. Just the FAX
3. Information provided at the time of the visit by a Provider Service Representative
4. State reports available to the public

Define the process and give step by step procedures and work-flows within departments and between work areas as applicable.

N/A

Policy

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks	Policy No. MHU-PS-011
Title: MHU – VP Network Management	Policy Title: Primary Care Provider's Role
Signature:	Department Name: Provider Services
Approval Date:	Effective Date: 9/1/02
<i>If Required:</i>	Reviewed and Revised Date: 9/03, 1/04, 2/05, 4/07, 5/09, 11/12, 6/13, 3/14 ID 08/17, ID 8/18
Approver Name:	Review Only Date: 2/06, 2/10, 2/12, 2/13, 2/14, 2/15, 2/16, 2/17
Title:	Supersedes and replaces:
Signature:	N/A
Approval Date:	

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<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP
<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN <input checked="" type="checkbox"/> ID Medicaid Plus

References (s): *(Identify if this policy references another policy or contract requirement.)*
N/A

Departments identified in the policy:
Provider Services

Oversight Committee:
Member Provider Satisfaction Committee (MPSC)

I. PURPOSE

To have an established consistent practice of ensuring Molina Healthcare of Utah (MHU) has an adequate network of primary care providers.

II. POLICY

Molina Healthcare of Utah (MHU) maintains a Primary Care Provider (PCP) model of healthcare delivery. MHU will maintain an adequate network of contracted PCPs for its members.

III. DEFINITIONS

MHU defines PCPs as Family Practice Physicians, Family Nurse Practitioners, Pediatricians, Pediatric Nurse Practitioners, Obstetricians/Gynecologists, Certified Nurse Midwives, Internal Medicine Physicians and Physician Assistants affiliated with any of the above providers. In order for a practitioner to become a contracted MHU PCP, he/she must meet the criteria outlined in MHU's Credentialing Policies and Procedures.

SLT Signature (*if expedited*): _____ **Date:** _____

Procedure

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks Title: MHU – VP of Network Management Signature: Approval Date:	Procedure Title: Primary Care Provider's Role
	Policy No. Reference: MHU-PS-011
	Policy Title Reference: Primary Care Provider's Role
	Department Name: Provider Services
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	Effective Date: 9/1/02
	Supersedes and replaces: N/A
	Review only date: 2/06, 2/10, 2/12, 2/13, 2/14, 2/15, 2/16, 2/17
	Reviewed and Revised Date UT 9/03, 1/04, 2/05, 4/07, 5/09, 11/12, 6/13, 3/14 ID 08/17, ID 8/18

Line of business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid
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<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP
<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN <input checked="" type="checkbox"/> ID Medicaid Plus

Description of process and procedure/service:

A. Provider's Role:

1. PCP's provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements. This also includes the following:
 -
2. When referrals for specialty services or diagnostic procedures are necessary the PCP will make a referral, obtain authorizations as appropriate and coordinate the care. (Specialists will be responsible to obtain their own authorizations for care as needed at the time of the initial visit and thereafter as required.)
3. PCP's are required to have hospital privileges at a MHU contracted facility and to provide inpatient care for their patients unless other

arrangements have been approved by MHU through the credentialing process.

4. PCP's will make necessary and appropriate arrangements to assure the availability of Covered Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member visits after hours. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.
5. PCP's shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
6. PCP's shall participate in Molina's Grievance Program, Quality Improvement Program, and the Utilization Review and Management Program, and comply with all policies and procedures as directed by the MHU Health Plan.

Define the process and give step by step procedures and work-flows within departments and between work areas as applicable.

MHU's Provider Services Team will educate contracted providers on the procedures for meeting the requirements of the policy.

Addendum A: Molina Healthcare of Idaho State Specific Primary Care Provider's Role Requirements

Description of process and procedure/service:

A. Provider's Role and Responsibilities:

1. PCP's shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment. Further they shall abide by all applicable rules and/or standards of professional conduct, including any controlling governmental licensing requirements.
2. When referrals for specialty services or diagnostic procedures are required the PCP will make a referral, obtain authorizations as appropriate and coordinate the care. (Specialists will be responsible to obtain their own authorizations for care as needed at the time of the initial visit and thereafter as required.)
3. PCP's are required to have hospital privileges at a MHU contracted facility and to provide inpatient care for their patients unless other arrangements have been approved by MHU through the credentialing process.
4. PCP's will make necessary and appropriate arrangements to assure the Availability of Covered Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member visits after hours. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.
5. PCP's will make necessary and appropriate arrangements to assure the Availability of Covered Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member visits after hours. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.
6. PCP's shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
7. PCP's shall participate in Molina's Grievance Program, Quality Improvement Program, the Utilization Review and Management Program, and comply with all policies and procedures as directed by the MHU Health Plan.
8. Provide primary medical services; including acute and preventative care.

9. Shall participate in training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, wellness principles, how to identify behavioral health and LTSS needs, and the ADA/Olmstead requirements.
10. Refer Enrollees, in coordination with the ICT and in accordance with the Health Plan's policies and procedures, to Covered Services Providers as Medically Necessary; and
11. Participate in the ICT in collaboration with the Care Coordinator, and if indicated, with the behavioral health clinician.
12. For Home and community based services, referral for PCP is not required. HCBS will be determined through the member's assessment.

Define the process and give step by step procedures and work-flows within departments and between work areas as applicable.

MHU's Provider Services Team will educate contracted providers on the procedures for meeting the requirements of the policy.

Policy

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks	Policy No. MHU-PS-17
Title: MHU – VP of Network Management	Policy Title: Access to Medical Care
Signature:	Department Name: Provider Services
Approval Date:	Effective Date: 7/1/09
<i>If Required:</i>	Reviewed and Revised Date: 8/11, 2/12, 11/12, 3/14, 2/16, 8/16, ID 8/17, ID 8/18
Approver Name:	Review Only Date: 2/10, 2/13, 6/13, 2/14, 2/15, 2/17
Title:	Supersedes and replaces:
Signature:	N/A
Approval Date:	

Line of Business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> ID Medicaid Plus
	<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)
<input checked="" type="checkbox"/> Medicare/Medicaid Duals <input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN	<input checked="" type="checkbox"/> Health Insurance Marketplace
<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP

References (s): *(Identify if this policy references another policy or contract requirement.)*
N/A

Departments identified in the policy:
Provider Services

Oversight Committee:
Member Provider Satisfaction Committee (MPSC)

I. PURPOSE

To ensure members of Molina Healthcare of Utah (MHU) have adequate access to primary care providers and to ensure MHU is in compliance with National Committee for Quality Assurance (NCQA) standards for access to care.

MHU maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted primary care providers (PCP) (adult and pediatric) and participating specialists, including but not limited to OB/GYN, behavioral health practitioners and high volume specialists.

MHU will monitor and ensure that members have access to and receive health care services within the timeframes specified by the access standards.

MHU will implement corrective actions for access to health care services that do not meet performance standards.

II. POLICY

MHU is responsible for providing and maintaining appropriate access to primary medical care and services to all Members. MHU is required to comply with access standards set forth by NCQA regulators.

- A. All MHU members will have access to health care services that meet MHU and regulatory agency standards.
- B. MHU establishes standards and mechanisms to monitor and ensure the accessibility of health care for members.
- C. PCPs and other physicians serving all MHU members are to implement an appointment scheduling system.
- D. MHU continuously monitors the provider networks' compliance with these standards, and takes corrective action as necessary.
- E. MHU ensures that the hours of operation of its providers are convenient for and do not discriminate against members. When medically necessary, Molina Plans make services available 24 hours a day, 7 days a week.
- F. Provide or arrange for necessary specialist care, and in particular give female enrollees the option of direct access to women's healthcare specialist within the network for women's routine and preventative healthcare services.
- G. Annually, MHU conducts an appointment and after-hour accessibility audit on a defined sample of primary care physicians, high volume specialists, high impact specialists and behavioral healthcare practitioners. Monitoring and evaluation includes a review of member complaints related to accessibility, scheduling process, wait times and delays which is also conducted on an ongoing basis.
- H. MHU adopts the following appointment availability standards and may adjust according to local network or regulatory requirements:
 - 1. *Preventive primary care appointments and school physicals:* Office visit is available from the member's primary care practitioner (PCP) or alternative practitioner within acceptable timeframes consistent with the region specific standards of care. Acceptable timeframes are within thirty (30) calendar days for adults and children. Visits may include but are not limited to non-symptomatic well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

2. *Routine primary care appointments:* Office visit is available from the member's PCP or an alternative practitioner within acceptable timeframes consistent with the region specific standards of care. Acceptable timeframes are within twenty-one (21) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.
 3. *Urgent primary care appointments:* Office visit is available within twenty-four (24) hours and no longer than the following business day. An urgent office visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.
 4. *Emergency care:* Emergency medical care is available twenty-four (24) hours a day, seven (7) days a week. PCPs must provide members access by telephone information on use of 911 and instructions about how to access medical advice concerning emergent medical conditions.
 5. *After-hours care:* Care after business hours is available by telephone twenty-four (24) hours a day, seven (7) days a week when medically necessary. PCPs must provide members access by telephone or instructions about how to access medical advice concerning urgent medical conditions
 6. *Office wait time:* Wait time from scheduled appointment until seen by PCP must be less than 45 minutes.
- I. The appointment availability standards below are for all specialists, however, MHU defines the following specialists in accordance with NCQA standards:
1. "High Impact" specialists are those that treat specific conditions that have serious consequences for Molina members and require significant resources and treat a significant portion of the organization's membership. The top 5 specialty types include the following: Oncology, Surgery, Orthopedic Surgery, Endocrinology and Gastroenterology. Other specialty types maybe considered "High Impact" depending on the plan's line of business.
 2. "High Volume" specialists are those who treat a significant portion of Molina's membership.
- J. Specialist office visits are available within acceptable timeframes consistent with the region specific standards of care. Acceptable timeframes are within two (2) days for urgent, symptomatic, but not life threatening care. (Care that can be treated in a doctor's office.) For routine, non-urgent Specialist office visits, acceptable timeframes are within thirty (30) days.
1. *Routine behavioral healthcare appointments:* Office visits for a behavioral healthcare practitioner is available within ten (10) business days.

2. *Non-life threatening emergency:* Behavioral healthcare non-life threatening emergency care is available within six (6) hours.
 3. *Urgent behavioral healthcare appointments:* Urgent behavioral healthcare office visits must be available within forty-eight (48) hours.
 4. *Follow up routine behavioral healthcare appointments:* Office visits for follow up routine care are available within thirty (30) calendar days from previous appointment.
- K. MHU monitors performance to established performance standards for each access standard to identify areas of opportunity within the provider network and implements action when gaps in performance are identified.
- L. Access to care standards are distributed to MHU providers through a variety of mechanisms, including but not limited to new practitioner orientation materials, provider manuals, policy bulletins, and the MHU website.(www.molinahealthcare.com).

III. DEFINITIONS

N/A

SLT Signature (if expedited): _____ Date: _____

Procedure

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks Title: MHU – VP of Network Management Signature: Approval Date:	Procedure Title: Access to Medical Care
	Policy No. Reference: MHU-PS-17
	Policy Title Reference: Access to Medical Care
	Department Name: Provider Services
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	Effective Date: 6/1/09
	Reviewed and Revised Date: 8/11, 2/12, 11/12, 3/14, 2/16, 8/16 ID 8/17, ID 8/18
	Review Only Date: 2/10, 2/13, 6/13, 2/14, 2/15, 2/17
	Supersedes and replaces: N/A

Line of Business: <i>(Please click all that apply)</i>		
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid	<input checked="" type="checkbox"/> ID Medicaid Plus
<input checked="" type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input checked="" type="checkbox"/> Health Insurance Marketplace	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN
<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP	<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)

Description of process and procedure/service:

- A. Access to care standards are reviewed, revised as necessary and approved by the appropriate Plan Committee on an annual basis.
- B. Provider network adherence to access standards is monitored via the following mechanisms:
 1. Provider access studies – provider office assessment of appointment availability and after-hours access.
 2. Member complaint data – assessment of member complaints related to access to care.
 3. Member satisfaction survey – evaluation of members' self-reported satisfaction with appointment and after-hours access.
- C. Analysis of access data includes assessment of performance against established standards, review of trends over time and identification of barriers.

- D. Results of analysis are reported to the appropriate Committee(s) at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends.
- E. Performance goals are reviewed and approved annually by the appropriate Committee.
- F. Measuring performance against standards will be conducted routinely by reviewing the following:
1. **Access:** MHU will compare access questions within the CAHPS Member Satisfaction Survey to assess member perception with access to health care. The following CAHPS questions will be used:
 - a. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
 - b. In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
 - c. CAHPS Composite: Getting Care Quickly

MHU's score for the questions above will be compared to national benchmarks. MHU's goal will be to score at or above the 75th percentile of Medicaid plans.
 2. **After hours:** A representative from QI will call MHU PCP offices after-hours and assess the after-hours phone message. The sample will be random and will be statistically significant. Provider's after-hours phone message will be scored to see if the message allows members to talk to a provider for an after-hours need. A referral to an after-hours nurse hotline for triage will meet the requirement. A report will be generated listing those providers that did not meet the after-hours requirements and send to Provider Services.
 3. **Complaints:** A QI Specialist will gather the complaint data from call tracking module in QNXT for the member complaint category: access/availability and present the report to MPSC.
- G. Provider Services will follow up with a letter outlining the requirements and ask each provider that did not meet the requirements to make the changes needed to meet the requirement within thirty (30) days from the date of the letter.
- H. MHI will call the office at the end of the thirty (30) day timeframe and assess if the provider meets the requirements.
- I. If the provider does not meet the access and availability requirements, the provider will be reconsidered at the Professional Review Committee (PRC).

- J. The PRC will give consideration to providers in rural areas that may have minimal or no resources to meet the requirements.
- K. The Credentialing Coordinator will log information in the credentialing system as a Quality Event for providers that do not meet the after-hours requirements. Three (3) Quality Events in a twelve (12) month time period will also trigger a reconsideration at the PRC.

Addendum Molina Healthcare of Idaho State Access to Medical Care Procedure

Description of process and procedure/service:

- A. Access to care standards are reviewed, revised as necessary and approved by the appropriate Plan Committee on an annual basis.
- B. Provider network adherence to access standards is monitored via the following mechanisms:
 - 1. Provider access studies – provider office assessment of appointment availability and after-hours access.
 - 2. Member complaint data – assessment of member complaints related to access to care.
 - 3. Member satisfaction survey – evaluation of members' self-reported satisfaction with appointment and after-hours access.
- C. Analysis of access data includes assessment of performance against established standards, review of trends over time and identification of barriers.
- D. Results of analysis are reported to the appropriate Committee(s) at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends.
- E. Performance goals are reviewed and approved annually by the appropriate Committee.
- F. Measuring performance against standards will be conducted routinely by reviewing the following:
 - a. **Access:** MHU will compare access questions within the CAHPS Member Satisfaction Survey to assess member perception with access to health care. The following CAHPS questions will be used:
 - 1. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
 - 2. In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
 - 3. CAHPS Composite: Getting Care Quickly

MHU's score for the questions above will be compared to national benchmarks. MHU's goal will be to score at or above the 75th percentile of Medicaid plans.
 - b. **After hours:** A representative from QI will call MHU PCP offices after-hours and assess the after-hours phone message. The sample will be random

and will be statistically significant. Provider's after-hours phone message will be scored to see if the message allows members to talk to a provider for an after-hours need. A referral to an after-hours nurse hotline for triage will meet the requirement. A report will be generated listing those providers that did not meet the after-hours requirements and send to Provider Services.

- c. **Complaints:** A QI Specialist will gather the complaint data from call tracking module in QNXT for the member complaint category: access/availability and present the report to MPSC.
- G. Provider Services will follow up with a letter outlining the requirements and ask each provider that did not meet the requirements to make the changes needed to meet the requirement within thirty (30) days from the date of the letter.
- H. MHI will call the office at the end of the thirty (30) day timeframe and assess if the provider meets the requirements.
- I. If the provider does not meet the access and availability requirements, the provider will be reconsidered at the Professional Review Committee (PRC).
- J. The PRC will give consideration to providers in rural areas that may have minimal or no resources to meet the requirements.
- K. The Credentialing Coordinator will log information in the credentialing system as a Quality Event for those providers not meeting the after-hours requirements. Three (3) Quality Events in a twelve (12) month time period will also trigger reconsideration at the PRC.
- L. Comply with Medicaid Managed Care availability standards established at 42 CFR § 438.206-207, ensuring the Health Plan and its providers meet State standards for timely access to care and services, taking into account the urgency of need for services.
- M. Have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollees' condition and identified needs for Enrollees needing a course of treatment or regular care monitoring.
- N. Not require a PCP referral for Enrollees to access behavioral health services.
- O. Not require a PCP referral for pregnant Enrollees to access prenatal care.
- P. The Health Plan may require Enrollees to seek a referral from a PCP prior to accessing some or all non-emergency specialty physical health services.
- Q. Comply with federal law regarding access to Federally Qualified Health Centers (FQHCs). If the Health Plan does not have an in-network FQHC that meets the General Access Standards, the Health Plan shall allow its Enrollees to seek care from an out-of-network FQHC, if available.

1. The Health Plan shall reimburse any FQHC or Rural Health Clinic at the rates provided in Section 1902(bb) of the Social Security Act.
 2. The Department will provide current price lists with reimbursement rates for FQHCs and Rural Health Clinics.
- R. Allow female Enrollees direct access (without requiring a referral) to a women's health specialist who is an in-network Provider for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Enrollee's designated source of primary care if that source is not a women's health specialist per 42 CFR § 438.206.
- S. Provide a sixty (60) calendar day advance notice whenever possible to IDHW of changes to the network that may affect access, availability, or network composition.
- T. Ensure there are sufficient numbers of PCPs who accept new Enrollees to meet the access standards provided in Attachment 8 - *Access Standards*.

MOLINA HEALTHCARE of UTAH

Policy No. PS-20

Department: PROVIDER SERVICES

Title: New Provider Orientation

Approved by:
John Oaks, VP of Network Management

Effective Date: February 2012

Reviewed Only Date: 2/13, 2/15, ID 8/17, ID 8/18

Date:

Reviewed and Revised Date: 11/12, 6/13, 2/14, 3/14, 2/16

Signature:

**Supersedes and replaces:
Date:**

Applies to	Medicaid	Medicare	CHIP	Molina Exchange Products	MEDICARE	ID Medicaid plus	LONG TERM SERVICES AND SUPPORT (LTSS)	
	x	x	x	x	X	X		

Policy

References (s): *(Identify if this policy references another policy or contract requirement.)*
N/A

Departments identified in the policy:
Provider Services

Oversight Committee:
Member Provider Satisfaction Committee (MPSC)

I. Purpose

To establish a timeline for all new provider orientations to be completed and to outline required topics to be covered within the orientation presentation.

II. Policy

It is the policy of MHU to educate newly contracted providers. The Provider Services Representative is required to make contact with a newly contracted provider within 30 days of the effective date of the new contract.

III. Definitions

N/A

SLT Signature (if expedited): _____ Date: _____

Procedure

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks Title: MHU – VP of Network Management Signature: Approval Date: Enter date here	Procedure Title: New Provider Orientation
	Policy No. Reference: MHU-PS-20
	Policy Title Reference: New Provider Orientation
	Department Name: Provider Services
<i>If Required:</i> Approver Name: Enter text here Title: Enter text here Signature: Approval Date: Enter date here	Effective date: 02/2012
	Reviewed and Revised Date: 11/12, 6/13, 2/14, 3/15, 2/16, ID 08/17
	Review Only Date: 2/13, 2/15, ID 08/18
	Supersedes and replaces: N/A

Line of business: (Please click all that apply)	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> ID Medicaid Plus
<input checked="" type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input checked="" type="checkbox"/> Health Insurance MarketPlace
<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP
<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN

I. Procedure:

- a. On a weekly basis the Contract Coordinator e-mails a report of all newly contracted providers to all MHU Departments, including the Provider Service Representatives. This report lists all newly contracted providers and provider joining existing groups.
- b. The Provider Service Representative will review the report to identify new groups/facilities that require orientation. Providers joining existing groups do not require orientation.

- c.** The Provider Services Representative will contact the provider/office to schedule the orientation within one month of the provider's contract effective date.
 - 1.** Required topics:
 - a)** New Provider Welcome Packet
 - i. Reporting suspected domestic violence, abuse or neglect
 - ii. Cultural Diversity Training
 - iii. Non Discrimination Compliance Plan
 - b)** Medicare Risk Assessment – as applicable
 - c)** Medicare annual well visits CPT codes – as applicable
 - 2.** The Provider Services Representative will document in the QNXT Call Tracking the date and Provider contact name that received the orientation.

Policy

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks	Policy No. MHU-PS-021
Title: MHU – VP of Network Management	Policy Title: Joint Operations Committee
Signature:	Department Name: Provider Services
Approval Date:	Effective Date: 9/1/09
<i>If Required:</i>	Reviewed and Revised Date: 6/13,03/14, ID 8/17
Approver Name:	Review Only Date: 02/12,02/13,02/15,02/16, ID 8/18
Title:	Supersedes and replaces:
Signature:	N/A
Approval Date:	

Line of business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> ID Medicaid Plus
<input checked="" type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input checked="" type="checkbox"/> Health Insurance MarketPlace
<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP
<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN

References (s): *(Identify if this policy references another policy or contract requirement.)*

N/A

Departments identified in the policy: Provider Services

Oversight Committee: Member Provider Satisfaction Committee (MPSC)

I. PURPOSE

To establish a consistent practice of meeting with provider groups in order to provide information and education on new and established processes and to identify and resolve identified issues.

II. POLICY

Molina Healthcare of Utah (MHU) representatives meet with ancillary and large medical provider groups to discuss and educate on new and established processes and to identify any operational problems. This is a forum for provider group and MHU staff to meet and facilitate a more productive interaction.

Meet monthly, bi-monthly or quarterly based on provider or Molina request.

III. DEFINITIONS

N/A

SLT Signature *(if expedited):* _____ **Date:** _____

Procedure

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks Title: MHU – VP of Network Management Signature: Approval Date:	Procedure Title: Joint Operations Committee
	Policy No. Reference: MHU-PS-021
	Policy Title Reference: Joint Operations Committee
	Department Name: Provider Services
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	Effective Date: 9/1/09
	Supersedes and replaces: N/A
	Reviewed and Revised: 6/13,03/14, ID 8/17
	Reviewed only: 02/12,02/13,02/15,02/16, ID 8/18

Line of Business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> ID Medicaid Plus
<input checked="" type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input checked="" type="checkbox"/> Health Insurance Marketplace
<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP
<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN

Description of process and procedure/service:

Provider Service Representative will chair this meeting.

1. If a meeting time has not been established, the Chair will contact the provider group to schedule reoccurring meetings.
2. Identify attendees. Regular attendees are listed as members. Molina invitees will include a representative from the following departments: Claims, Utilization Management, Provider Services, Contracting and Medicare. Optional invitees from Molina can be, but not limited to, representatives from Pharmacy, Health Education and Appeals. Provider group will identify which departments will attend meeting.
3. Chair will schedule meeting for Molina Healthcare attendees (both members and guests) through Microsoft Outlook to get it on their calendars.
4. Prior to the meeting, Chair will request agenda items from all attendees (Molina Healthcare and provider group.) Agenda should include title of Molina / Provider Group on the agenda with the date, time, location, attendees, guests, committee

purpose and meeting dates, agenda items which include introduction, agenda review, and review of minutes, follow-up agenda items, standing agenda items if pertinent, new business, and attachments (see attached sample.)

5. One week prior to meeting, Chair will send agenda and minutes from previous meeting to both Molina attendees and provider group.
6. When the meeting is in session, the Chair will have copies of the agenda available, along with minutes from the previous meeting and any other materials for distribution to all attendees.
7. The Chair will start the meeting asking members to review, make any needed changes and approve the agenda and minutes.
8. The Chair will address outstanding follow-up items and ask for any updates.
9. The Chair is responsible to document meeting minutes. The Chair will also document who is responsible for follow-up action items and due date if necessary.

Define the process and give step by step procedures and work-flows within departments and between work areas as applicable.

MHU's Provider Services Team will educate contracted providers on the procedures for meeting the requirements of the policy.

Policy

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks	Policy No. MHU-PS-22
Title: MHU – VP of Network Management	Policy Title: Post Appointment Survey
Signature:	Department Name: Provider Services
Approval Date:	Effective Date: 9/26/03
<i>If Required:</i>	Reviewed and Revised Date: 9/13, 2/16, ID 8/17
Approver Name:	Review Only Date: 3/14, 2/15, 2/17, ID 8/18
Title:	Supersedes and replaces:
Signature:	N/A
Approval Date:	

Line of Business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> ID Medicaid Plus
<input type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input checked="" type="checkbox"/> Health Insurance Marketplace <input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)
<input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN	<input type="checkbox"/> Other: CHIP

References (s): *(Identify if this policy references another policy or contract requirement.)*
N/A

Departments identified in the policy:
Provider Services

Oversight Committee:
Member Provider Satisfaction Committee (MPSC)

I. PURPOSE

Establish a process whereby Molina Healthcare of Utah (MHU) and MHI Member Engagement Teams will monitor and ensure that members have access to appropriate health care services in reasonable timeframes, and are satisfied with the care they receive.

II. POLICY

To outline how the MHU Provider Services Team will retrieve survey data from the Member Portal on a monthly basis, track provider compliance with established benchmarks, and follow up process for educating non-compliant providers.

MHU responsibilities:

- A. Program costs, including printing/mailing

- B.** Provide the MHI Member Engagement team with quarterly summaries
- C.** Continue to follow up with Provider Services on survey results, especially if survey benchmarks are not met as outlined in the Policy and Procedure
- D.** LOBs include: Medicaid and Medicare
 - 1.** Medicare not participating in raffles due to regulatory restrictions
 - 2.** If health plan decides to include duals, then all materials (includes survey and postcard) will require OML and state approval. MHU will work with MHI Portal Team to turn “on” survey capabilities.

MHI Member Engagement Team responsibilities:

- A.** Will act as a governing committee
- B.** Receive quarterly reports from health plans
- C.** Will act as liaison for health plan and portal team if plans decide to add D-SNP LOB to survey

III. DEFINITIONS

N/A

SLT Signature (*if expedited*): _____ **Date:** _____

Procedure

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks	Procedure Title: Post Appointment Survey
Title: MHU – VP of Network Management	Policy No. Reference: MHU-PS-22
Signature:	Policy Title Reference: Post Appointment Survey
Approval Date:	Department Name: Provider Services
<i>If Required:</i>	Effective Date: 9/26/13
Approver Name:	Reviewed and Revised Date: 9/13, 2/16, ID 8/17
Title:	Review Only Date: 3/14, 2/15, 2/17, ID 8/18
Signature:	Supersedes and replaces:
Approval Date:	N/A

Line of Business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> ID Medicaid Plus
<input type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input type="checkbox"/> Health Insurance Marketplace
<input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN	<input type="checkbox"/> Other: CHIP <input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)

Description of process and procedure/service:

- A. Provider Services Representative (PSR) will download monthly survey data from the Member Portal using the Web Reporting Tool on the last Friday of each month.
 1. PSR will post the monthly survey report as an MS Excel spreadsheet to the MHU Provider Services SharePoint site.
 2. PSR will evaluate the survey data based on established benchmarks.
 3. PSR will notify Provider Services Director/Manager of any MHU network providers who are not in compliance with established benchmarks.
- B. Provider Services Director/Manager will assign outreach tasks to PSR based on territory or otherwise as needed.
 1. Provider Services Director/Manager will notify PSR that outreach is required to be completed within 30 days of receiving the issue.
 2. The assigned PSR will open issue in QNXT Call Tracking.

- C. PSR will perform phone, e-mail or on-site outreach as appropriate to the deficiency. Outreach type is at the discretion of the Provider Services Director/Manager.
 - 1. PSR will inform provider of negative survey result and educate provider per MHU policies and procedures, and inform provider that a subsequent negative survey result could result in referral to MHU QI Department.
 - 2. PSR will log all contact with provider in QNXT Call Tracking and send issue to Provider Services Director/Manager for review.
 - 3. PSR will inform Provider Services Director/Manager when outreach is complete.
- D. PSR assigned will log outreach and education in monthly report on MHU Provider Services SharePoint site.
- E. Provider Services Director/Manager will review issue in QNXT Call Tracking and:
 - 1. Close issue if outreach and education are sufficient to resolve issue stemming from negative survey result, or
 - 2. forward issue to MHU QI Department if corrective action is required.

Define the process and give step by step procedures and work-flows within departments and between work areas as applicable.

MHU's Provider Services Team will educate contracted providers on the procedures for meeting the requirements of the policy.

Addendum Molina Healthcare of Idaho State Specific Post Appointment Survey requirements

Description of process and procedure/service:

- A.** Provider Services Representative (PSR) will download monthly survey data from the Member Portal using the Web Reporting Tool on the last Friday of each month.
 - 1.** PSR will post the monthly survey report as an MS Excel spreadsheet to the MHU Provider Services SharePoint site.
 - 2.** PSR will evaluate the survey data based on established benchmarks
 - 3.** PSR will notify Provider Services Director/Manager of any MHU network providers who are not in compliance with established benchmarks.
- B.** Provider Services Director/Manager will assign outreach tasks to PSR based on territory or otherwise as needed.
 - 1.** Provider Services Director/Manager will notify PSR that outreach is required to be completed within 30 days of receiving the issue.
 - 2.** The assigned PSR will open issue in QNXT Call Tracking.
- C.** PSR will perform phone, e-mail or on-site outreach as appropriate to the deficiency. Outreach type is at the discretion of the Provider Services Director/Manager.
 - 1.** PSR will inform provider of negative survey result and educate provider per MHU policies and procedures, and inform provider that a subsequent negative survey result could result in referral to MHU QI Department
 - 2.** PSR will log all contact with provider in QNXT Call Tracking and send issue to Provider Services Director/Manager for review.
 - 3.** PSR will inform Provider Services Director/Manager when outreach is complete.
- D.** PSR assigned will log outreach an education in monthly report on MHU Provider Services SharePoint site.
- E.** Provider Services Director/Manager will review issue in QNXT Call Tracking and:
 - 1.** Close issue if outreach and education are sufficient to resolve issue stemming from negative survey result, or
 - 2.** Forward issue to MHU QI Department if corrective action is required.
- F.** Conduct surveys and office visits to monitor Provider compliance with appointment waiting time standards and report findings and corrective actions as described in the Reports Section. IDHW

reserves the right to direct the Health Plan to terminate or modify any Network Provider Subcontract when IDHW determines it to be in the best interest of the State.

G. Provider Network Report—Timeliness of Services Report—MHU shall submit a detailed report that includes the following:

1. Results of the Health Plan's survey of Providers, sorted by the categories identified Attachment 7- *Access Standards*, which identifies the percent of Providers who have met the acceptable timeframe requirements identified in the Service Delivery Standards section of the attachment;
2. Any justification for providers not meeting the Access Standard requirements;
3. Trends in Providers not meeting the Access Standard requirements, i.e. areas of the state affected, provider types not meeting the standard, etc. and the Health Plan's specific plans to address these trends.
 - i. Report Format: MS Excel
 - ii. Reporting Phase: Ongoing
 - iii. Report Due: Annually

Define the process and give step by step procedures and work-flows within departments and between work areas as applicable.

MHU's Provider Services Team will educate contracted providers on the procedures for meeting the requirements of the policy.

Procedure

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks Title: MHU- VP of Network Management Signature: Approval Date:	Procedure Title: Provider Education & Training
	Policy No. Reference: MHU-PS-25
	Policy Title Reference: Provider Satisfaction
	Department Name: Provider Services
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	Effective date: 01/01/2016
	Reviewed and Revised Date: UT 2/17, ID 8/17
	Review Only Date: 1/04, 2/06, 4/07, 2/10, 2/12, 11/12, 6/13, 3/14, 2/16, ID 8/18
	Supersedes and replaces: MHI PS-55

Line of business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> ID Medicaid Plus
<input checked="" type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input checked="" type="checkbox"/> Health Insurance MarketPlace
<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP
<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN

References:

MHI PS-55

Description of process and procedure/service:

- A. Provider education and training will be performed by Molina Healthcare state-level health plan Provider Services Department.
- B. Molina Healthcare state-level health plan Provider Services Department staff shall develop, conduct and evaluate continual Provider education and training programs and shall collaborate with all applicable departments and external organizations as necessary to address specific training topics. These programs shall include, but not be limited to the following topics annually, quarterly, or on an as needed basis:
 1. Provider orientation training shall be scheduled and conducted upon full execution of the Provider Service Agreement and when the provider is placed in an “active” status.
 2. Molina Healthcare defines “active” status as the point at which the provider is assigned membership or is allowed to perform services.

3. Training shall be based upon Molina Healthcare's processes and procedures, the Centers for Medicare and Medicaid Services ("CMS"), National Committee for Quality Assurance ("NCQA") and all applicable state and federal regulations. The Molina Healthcare state level health plan Provider Services Department shall provide oversight on timeliness of initial trainings.
4. Training shall include, but not be limited to those topics outlined below:
 - An overview of the Provider Services Agreement and the Provider Manual, including how to access the manual on the Molina Healthcare website.
 - Provider's role and collaboration with Molina Healthcare to ensure members receive appropriate care and access to services.
 - Training on disability awareness and sensitivity in accordance with the American Disabilities Act ("ADA"). In addition to cultural and linguistic competency and location of resources for members. Members Rights and Responsibilities
 - Web Portal and website information, including how to access the provider on-line directory.
 - Instructions on how to report provider demographic updates to Molina Healthcare in accordance with the Provider Services Agreement.
 - Additional provider training shall occur, as needed and/or upon request (i.e., quarterly, monthly). The utilization of periodic communications shall include, but not be limited to, US Mail, face-to-face presentations, facsimiles, newsletters, webinars and Molina Healthcare's provider website/portal.
5. Joint Operations Committee/Meeting, inclusive of plan and medical group or management company representatives shall be held once a year, at a minimum. Targeted providers for participation may include, but not be limited multi-specialty provider groups and hospital systems.
6. Scheduling of formal training programs shall be coordinated by the Molina Healthcare state-level health plan provider services staff with documentation of education/training announcements and agenda, in coordination with applicable departments.
7. Record keeping for each training program shall contain the following information:
 - a. Program Title
 - b. Name and title of individual conducting program.
 - c. Location, date, time
 - d. Copy of attendance sheet signed by attendees
 - e. Program content description
8. Regulatory obligations and protocols for each applicable line of business.

Addendum A: Molina Healthcare of Idaho State Specific Provider Education and Training Requirement

I. Procedure

- A. Provider education and training will be performed by any of the following Provider Services Department staff members:
1. Provider Services Director
 2. Provider Services Manager
 3. Provider Services Representatives
- B. Staff will develop, conduct and evaluate continual provider education and training programs and collaborate with all applicable departments and external organization as necessary to address specific training topics. These programs will include, but are not limited to the following topics annually, quarterly, or on an as needed basis:
1. Initial provider training, including, but not limited to, how to utilize MHU's referral process, definition of their role in the Quality Improvement process, Appeal and Grievance process, and instructions on claims submissions.
 2. Understanding of provider contract.
 3. Overview and updates of the Provider Manual, including where to access the manual on the Molina website or requested printed copies of the Provider Manual.
 4. Overview and operations of the Molina Healthcare of Utah Medicare Medicaid Coordinated Plan (MMCP).
 5. Regulatory updates (statutes and regulations).
 6. Provider role and communication from MHU's Quality Improvement, Utilization Management, Member Services, Pharmacy, Claims, Encounters, and Health Care Services Departments.
 7. Training on disability awareness and sensitivity, cultural and linguistic competency and location of resources for all members, including seniors and Persons with Disabilities.
 8. Training on Model of Care, Coordination of Care, and Behavioral Health services, LTSS, community supports and other Medicare Medicaid Plan requirements and ensure access is provided.
 9. Training on provider billing and reporting, including no balance billing information.
 10. Training on Encounters, claim submission, appeals and grievances, and compensation information.
 11. Training on technical assistance regarding claims submission and resolution processes; prompt resolution of claims issues or inquiries, and payment withhold provisions.
 12. Training on the role of the Prepaid Inpatient Health Plan (PiHP) Behavioral Health component of the program.
 13. Training on LTSS, including, but not limited to, Community Based Adult Services, In Home Supportive Services, Multi-Purpose Senior Services Program and Skilled Nursing Facility/Sub acute Care Services. Training will include

information about how to identify LTSS needs, eligibility criteria, and how to appropriately refer for LTSS services.

14. Assistance in practice management processes.
15. Distribution of Member's Rights and Responsibilities.
16. Distribution of revised provider materials as needed.
17. Emergency Department protocols.
18. WebPortal and website information, including how to access the directory on the website.
19. Acceptable methods for sharing information between the plan, providers, and our members.
20. Legal obligations to comply with the ADA requirements.
21. Use of evidence-based practices and specific levels of quality outcomes.
22. Training on the Medical Home model and the importance of using it to integrate all aspects of each enrollee's care.
23. Information on how to become a Medical Home.

C. HCBS waiver provider training will consist of:

1. Education on the provider packets for Personal Assistants;
2. Process for provider packets distribution; and,
3. Enrollee's responsibilities for Personal Assistants under the Persons with Disabilities HCBS Waiver, Persons with Brain Injury HCBS Waiver, or Persons with HIV/AIDS HCBS Waiver.
4. Cultural competency for delivering services to enrollees.
5. Distribution of Cultural Competency Training for Healthcare Providers.
6. Connecting with your patients.

D. MHU will ensure the PIHP behavioral health network providers provide linguistically and culturally competent services.

E. The roles and responsibilities of the Interdisciplinary Care Team (ICT), including:

1. Communication pathways between provider, to include, but not limited to behavioral health and LTSS providers and the interdisciplinary care team;
2. Care plan development;
3. Consumer direction; and
4. Any HIT necessary to support care coordination.

F. MHU will ensure training for all providers and ICT members includes:

1. Coordinating with behavioral health and LTSS providers;
2. Information about accessing LTSS;
3. Lists of community supports available

- G. MHU will ensure all providers receive disability training for its medical, behavioral, and community-based and facility-based LTSS providers, including information about the following:
1. Various types of chronic conditions prevalent within the target population;
 2. Awareness of personal prejudices;
 3. Legal obligations to comply with the ADA requirements;
 4. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs;
 5. Types of barriers encountered by the target population;
 6. Training on person-centered planning (i.e., Person-Centered Service Plans) and self-determination, the social model of disability, the independent living philosophy, and the recovery model;
 7. Use of evidence-based practices and specific levels of quality outcomes.
 8. Working with enrollees with mental health diagnoses, including crisis prevention and treatments; and,
 9. Reporting abuse, neglect, exploitation and other critical incidents.
- H. Providers receive training information at the initiation of their contract, during monthly/quarterly provider touch visits and as needed and/or upon request. The utilization of periodic communication includes, but is not limited to, face-to-face presentations, facsimiles, "Just the Fax", mailings of newsletters, webinars and the MHU provider website.
- I. Joint Operation Committee meetings (JOCs), inclusive of plan and medical group or management company representatives are held quarterly, at a minimum.
- J. Scheduling of formal training programs will be handled by the Provider Services staff with documentation of education/training announcements and agenda, in coordination with applicable departments, including MHU's Quality Improvement, Utilization Management, Member Services, Encounter and Claims Department.
- K. Recordkeeping for each program is documented and maintained in the Provider Services department by the respective Director/Manager of Provider Services and contains the following information:
1. Program Title
 2. Name and title of the individual conducting the program
 3. Location, date and time
 4. Copy of attendance sheet signed by the attendees
 5. Program content description

L. Further tracking is performed via information obtained at the following points of provider contact:

1. Provider meetings: provider surveys will be conducted at the conclusion of training meeting sessions.
2. Provider Service Representative Visits: reports by Provider Service Representatives will include any training/education performed by the Representative, including location/date/time, participants and applicable training checklist/acknowledgement forms which are logged on various department reports.
3. Interdepartmental Contact: Internal departments, including, but not limited to, Utilization Services, and Claims, provide feedback via calls to the Provider Services Managers when a provider is experiencing difficulty in utilizing health plan services or enabling a member's proper use of those services.

M. Corrective action plans shall be requested from contracted network providers that fail to meet contractual and/or regulatory obligations or protocols for each applicable line of business.

N. Molina will ensure all providers (to include behavioral health providers through the PIHP and LTSS providers through the AAA, as applicable) receive training in physical accessibility, which is defined in accordance with U.S. Department of Justice ADA guidance for providers in the following areas:

1. Utilizing waiting room and exam room furniture that meet needs of all Enrollees; including those with physical and non-physical disabilities.
2. Accessibility along public transportation routes and/or provides enough parking.
3. Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities.
4. Molina will assure the PIHP trains BH, SUD, and I/DD providers on an annual basis in cultural competency for delivering services to Enrollees.

II. Program Description

New PCP Orientation

A. Mandatory education/training with the PCP will be scheduled within thirty (30) days of a PCP being placed on "active" status. MHU defines "active" status as the point at which the PCP is allowed to have members assigned. The Provider Services Director/Manager provides oversight on timeliness of initial trainings. Training includes, but is not limited to:

1. Provider Manual
2. Overview and operations of the Medicare Medicaid Coordinated Plan, and the Integrated Care Program, where applicable
3. Provider Web Portal training
4. Member Services training

5. Training on provider billing and reporting, including no balance billing information
6. Encounters, claim submission, appeals and grievances, and compensation information

B. Disability Awareness and Sensitivity Training regarding senior and persons with disabilities (SPDs) based on "Clinical Disabilities/Chronic Conditions" Providers will be trained on a continuing basis regarding clinical protocols and evidence based guidelines for SPDs or chronic conditions. The training shall include an educational program for providers regarding health needs specific in this population that utilizes a variety of educational strategies, including, but not limited to, information on MHU's website as well as other methods of educational outreach to providers.

1. Training on disability awareness and sensitivity, cultural and linguistic competency and location of resources for all members, including SPDs.
2. Training on Model of Care, Coordination of Care, Cultural Competency, and Behavioral Health services, LTSS, community supports and other Molina Healthcare of Utah program requirements and ensure access is provided.
3. Training on LTSS, including, but not limited to, Community Based Adult Services, In Home Supportive Services, Multi-Purpose Senior Services Program and Skilled Nursing Facility/Sub acute Care Services. Training will include information about how to identify LTSS needs, eligibility criteria, and how to appropriately refer for LTSS services.
4. Distribution of Member's Rights and Responsibilities.
5. Training on Practice Accessibility including, but not limited to, practice site visits to maintain acceptable standards.

C. Person-Centered Educational Opportunities Offered by IDHW and/or MHU Provider Services team assures it will:

1. Participate in train-the-trainer person-centered planning educational opportunities offered by IDHW;
2. Be responsible for training Molina Provider Services staff and network providers; and,
3. Report participation in the IDHW and/or MHU trainings as required.

D. Provider Education & Outreach Materials and Activities:

1. MHU shall develop and distribute Provider education and outreach materials pre-approved by IDHW. Electronic distribution is acceptable. Providers have the option to request hard copies free of charge. All materials shall be submitted to IDHW for review at least thirty (30) calendar days prior to expected use and distribution. All substantive changes to previously approved education and outreach materials shall be submitted to IDHW for review and approval at least thirty (30) calendar days prior to use. MHU shall revise, finalize, and return the documents to the IDHW for final review within ten (10) business days after receipt of revisions identified by the IDHW. Costs associated with developing, printing, and

distributing Provider education and outreach materials are the responsibility of MHU.

MHU shall Notify IDHW of significant changes that may affect Provider procedures at least thirty (30) calendar days prior to notifying its Provider network of the changes. MHU shall give Providers at least thirty (30) calendar days' advance notice of significant changes that may affect the Providers' procedures (e.g. changes in subcontractors, claims submission procedures, or prior authorization policies). MHU shall post a notice of the changes on its Provider website to inform both in-network and out-of-network Providers, and make payment Policies available to out-of-network Providers upon request.

2. Deliver training on Provider Policies and Procedures to all in-network Providers when they are initially enrolled into the Provider network, and whenever there are changes in policies or procedures, and upon a Provider's request.
3. Develop and include a MHU-designated inventory control number on all Provider education and outreach materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate IDHW's review and approval of materials and document the receipt and approval of original and revised documents. MHU shall also utilize this control number to track the status of approval internally.
4. Include the State program logo(s) in their marketing or other Provider communication materials upon IDHW request.
5. Obtain IDHW written approval, specific to the use requested, before using any of the following:
 - The Seal of the State of Idaho;
 - The IDHW name; or
 - Any other State agency name or logo.
6. Not interpret any approval given for the use of IDHW or other State agency name or logo as blanket approval.

Define the process and give step by step procedures and work-flows within departments and between work areas as applicable.

Policy

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks	Policy No. MHU-PS-026
Title: MHU – VP of Network Management	Policy Title: Provider Termination
Signature	Cross reference:
Approval Date:	PS 53- Provider Termination
	PS 50- Provider Directory
	PS 55-Provider Education and Training
	PS 58- Network Adequacy Standards
	Department Name: Provider Services
	Effective Date: 1/1/16
<i>If Required:</i>	Reviewed and Revised Date: 04/16,01/17, ID 07/17
Approver Name:	Review Only Date: 8/18
Title:	Supersedes and replaces:
Signature:	N/A
Approval Date:	

Line of business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> ID Medicaid Plus
<input checked="" type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input checked="" type="checkbox"/> Health Insurance MarketPlace
<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP
<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN

References (s): *(Identify if this policy references another policy or contract requirement.)*

MHI Policies

PS 53- Provider Termination

PS 50- Provider Directory

PS 55-Provider Education and Training

PS 58- Network Adequacy Standards

Departments identified in the policy:

Provider Services,

Oversight Committee:

Member Provider Satisfaction Committee (MPSC)

I. Purpose

The purpose of this policy is to ensure timely and proper notification of a Services Agreement (Contract) termination to Molina Healthcare (Molina) functional business

areas, the Centers for Medicare and Medicaid Services (CMS) and all applicable State and Federal agencies, as appropriate.

This policy shall comply with State-specific Medicaid regulations, Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections Section 110.1.2.2 and CMS Reference Code 42 CFR §156.230(d)(l), §422.111(e), §422.112(a)(l)(i), §422.202(d)(4), and §422.516(a).

In the event State and Federal regulations are in conflict, Molina state-level health plans shall comply with the more strict regulation

II. Policy

Molina and/or the Provider may initiate termination per the timelines and guidelines set forth in the Contract. The termination notification shall be in writing and shall include the effective date of the termination.

Molina shall provide written notification to all applicable State and Federal agencies, and appropriate authorities, when a Contract is suspended or terminated with a Provider due to deficiencies in the quality of care or whereby a significant change in the Provider network Occurs. Failure to notify regulatory agencies of significant network changes may result in compliance actions taken against Molina.

If the termination impacts Member assignment, timely and proper notification shall be made to the appropriate Molina functional business areas to ensure written notification to affected enrollees occurs.

The Provider record shall be termed in Molina's core operating system (QNXT), in accordance with the applicable governing policy and procedure.

III. DEFINITIONS

N/A

SLT Signature (*if expedited*): _____ **Date:** _____

Procedure

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks Title: MHU – VP of Network Management Signature: Approval Date:	Procedure Title: Provider Termination
	Policy No. Reference: MHU-PS-026
	Policy Title Reference: Provider Termination
	Department Name: Provider Services
	Cross reference: PS 50- Provider Directory PS 55-Provider Education and Training PS 58- Network Adequacy Standards
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	Effective Date: 1/1/16
	Supersedes and replaces: N/A
	Reviewed and Revised Date: 04/22/16, 01/01/2017, ID 08/17
	Review Only Date:8/18

Line of business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> ID Medicaid Plus
<input checked="" type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input checked="" type="checkbox"/> Health Insurance MarketPlace
<input checked="" type="checkbox"/> Medicare	<input checked="" type="checkbox"/> Other: CHIP
<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN

III. PROCEDURE

A. Termination Initiated by Provider

Molina shall process Provider initiated terminations as outlined within their Provider Contract. Molina shall adhere to all applicable State and Federal agency notification and reporting requirements.

Molina state-level health plans shall assess their Provider network to ensure network adequacy standards are not affected by the Contract termination. Refer to PS-58 Network Adequacy Standards for Medicare and Dual Options/MMP; for Medicaid and Marketplace, refer to your State-specific regulatory guidelines.

B. Termination Initiated by Molina Healthcare With or Without Cause

Molina shall give the affected Provider written notice of the reason(s) for the action for a termination initiated with or without cause. Molina shall process Provider terminations as

outlined within their Provider Contract. Molina shall adhere to all applicable State and Federal agency notification and reporting requirements.

The Fair Hearing process is outlined in the Contract and is defined in the Provider Fair Hearing Policy for a termination initiated with cause. (Note: not applicable to Medicare, Marketplace LOB).

Molina shall augment its Provider network if the specialty type is critical to the provider network.

A copy of the termination letter shall be filed in the Provider's contracting file.

C. Molina Functional Business Area Notification

Upon receipt of a Contract termination, Molina state-level health plans and MHI National Vendor Contracting shall provide notification to the Molina functional business areas listed below:

1. Medicare, Marketplace, Dual Options/MMP Compliance
2. State-Specific Government Contracts
3. Provider Configuration Management (PCM)
4. Enrollment Accounting

D. Regulatory Notification

1. Medicare, Dual Options/MMP

Molina state-level health plans and MHI National Vendor Contracting shall immediately notify Molina Medicare Compliance of any significant network termination via the Provider Contract Termination Notification Form at:

Medicare.ComplianceInquiries@MolinaHealthcare.com.

Molina Medicare Compliance shall provide notification to the CMS Account Manager within at least ninety (90) calendar days prior to the effective date of the change.

If CMS deems Molina's network change to be significant, then CMS may ask Molina to demonstrate its continued compliance with current CMS network adequacy standards through the submission of Health Service Delivery (HSD) tables.

2. Marketplace

Molina state-level health plans and MHI National Vendor Contracting shall immediately notify Molina Marketplace Compliance's AVP of any significant network termination via the Provider Contract Termination Notification Form.

Molina Marketplace Compliance shall provide notification to the appropriate Exchange Account Manager within at least sixty (60) calendar days prior to the effective date of the change.

3. Medicaid

When a significant change to the Molina Provider network occurs, including a national vendor, Molina state-level health plans shall notify applicable State agencies as required and follow their state-specific end-to-end processes.

In the event the termination is rescinded, notification shall be made to Molina functional business areas as outlined in III, C.

E. Enrollee Notification

1. All Lines of Business

When a significant change to the Molina Provider network occurs, Molina shall make a good faith effort to provide written notification to affected enrollees as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the change, unless otherwise required by applicable State-specific regulatory agencies.

2. The Provider record shall be termed in Molina's core operating system (QNXT), in accordance with the applicable governing policy and procedure maintained by the PCM functional business unit.

3. If the Provider Type is other than PCP, a claims report must be generated covering the three (3) months prior to the termination date. Additionally, a Prior Authorization Log must be reviewed to capture affected membership for Member notification.

4. Member notification shall be made in accordance with the applicable governing policy and procedure maintained by the Enrollment Accounting functional business unit.

F. Provider directory updates shall be made in accordance with the applicable governing policy and procedure, cross-referenced on page 1 of this Policy and Procedure.

G. Regulatory Reporting

Upon notification from regulatory agencies, Molina shall create, develop and submit any new mandatory reports and/or modify existing reports to comply with all applicable State and Federal agency regulations.

H. Molina state-level health plans are required to maintain Provider termination policies and/or Standard Operating Procedures (SOP) outlining state-specific end-to-end requirements and processes.

IV. DEFINITIONS

Significant Change – Contract termination which creates a network adequacy gap and/or affects a large number of Molina enrollees based upon network access standards by geographic type (i.e., Large Metro, Metro, Micro, Rural, CEAC).

CEAC – Counties with extreme access considerations.

V. ATTACHMENTS

Exhibit 1– Provider Contract Termination Notification Form

Exhibit 1 – Provider Contract Termination Notification Form –

PS-53 PROVIDER TERMINATION PROCESS

PROVIDER CONTRACT TERMINATION NOTIFICATION FORM

This form must be submitted to **Medicare, Dual Options/MMP, and/or Marketplace Compliance** when a significant change to the Molina Healthcare Provider network occurs. Significant change is hereby defined as any contract termination which creates a network adequacy gap and/or affects a large number of Molina enrollees based upon network access standards by geographic type (i.e., Large Metro, Metro, Micro, Rural, CEAC). **NOTE: Use existing state-specific processes and/or forms when notifying other Molina functional business areas (i.e., PCM**

Submit Completed Form Via Email (As Applicable)		
Medicare; Dual Options/MMP Compliance	Medicare.ComplianceInquiries@MolinaHealthcare.com	
Marketplace Compliance	Daniel.Barzman@MolinaHealthCare.com	
Molina Health Plan		
Submitted By		
Date Submitted		
Provider Type	<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Ancillary <input type="checkbox"/> Hospital <input type="checkbox"/> Other – Please Specify	
Termination Effective Date		<input type="checkbox"/> Health Plan Initiated <input type="checkbox"/> Provider Initiated
Provider TIN		
Provider Name		
Please provide a narrative as to the cause of the contract termination:		
Please provide the following data regarding the number of Affected Enrollees (if applicable to Provider type):		
Line of Business	# of Affected	County and/or Zip Codes Affected
Medicare		
Dual Options/MMP		
MarketPlace		
Will enrollees have to change PCP or Provider Group as a result of this termination?		
<input type="checkbox"/> No <input type="checkbox"/> Yes		
Will termination create a deficiency in network adequacy standards?		
<input type="checkbox"/> No <input type="checkbox"/> Yes – Provide details on resolution of deficiency below.		

Addendum Molina Healthcare of Idaho State Provider Termination Requirements

I. PROCEDURE

A. Termination Initiated by Provider

Molina shall process Provider initiated terminations as outlined within their Provider Contract. Molina shall adhere to all applicable State and Federal agency notification and reporting requirements.

Molina state-level health plans shall assess their Provider network to ensure network adequacy standards are not affected by the Contract termination. Refer to PS-58 Network Adequacy Standards for Medicare and Dual Options/MMP; for Medicaid and Marketplace, refer to your State-specific regulatory guidelines.

B. Termination Initiated by Molina Healthcare With or Without Cause

Molina shall give the affected Provider written notice of the reason(s) for the action for a termination initiated with or without cause. Molina shall process Provider terminations as outlined within their Provider Contract. Molina shall adhere to all applicable State and Federal agency notification and reporting requirements.

The Fair Hearing process is outlined in the Contract and is defined in the Provider Fair Hearing Policy for a termination initiated with cause. (Note: not applicable to Medicare, Marketplace LOB).

Molina shall augment its Provider network if the specialty type is critical to the provider network.

A copy of the termination letter shall be filed in the Provider's contracting file.

C. Molina Functional Business Area Notification

Upon receipt of a Contract termination, Molina state-level health plans and MHI National Vendor Contracting shall provide notification to the Molina functional business areas listed below:

1. Medicare, Marketplace, Dual Options/MMP Compliance
2. State-Specific Government Contracts
3. Provider Configuration Management (PCM)
4. Enrollment Accounting

D. Regulatory Notification

1. Medicare, Dual Options/MMP

Molina state-level health plans and MHI National Vendor Contracting shall immediately notify Molina Medicare Compliance of any significant network termination via the Provider Contract Termination Notification Form at:

Medicare.ComplianceInquiries@MolinaHealthcare.com.

Molina Medicare Compliance shall provide notification to the CMS Account Manager within at least ninety (90) calendar days prior to the effective date of the change.

If CMS deems Molina's network change to be significant, then CMS may ask Molina to demonstrate its continued compliance with current CMS network adequacy standards through the submission of Health Service Delivery (HSD) tables.

2. Marketplace

Molina state-level health plans and MHI National Vendor Contracting shall immediately notify Molina Marketplace Compliance's AVP of any significant network termination via the Provider Contract Termination Notification Form.

Molina Marketplace Compliance shall provide notification to the appropriate Exchange Account Manager within at least sixty (60) calendar days prior to the effective date of the change.

3. Medicaid

When a significant change to the Molina Provider network occurs, including a national vendor, Molina state-level health plans shall

notify applicable State agencies as required and follow their state-specific end-to-end processes.

In the event the termination is rescinded, notification shall be made to Molina functional business areas as outlined in III, C.

E. Enrollee Notification

1. All Lines of Business

When a significant change to the Molina Provider network occurs, Molina shall make a good faith effort to provide written notification to affected enrollees as soon as possible, but no less than thirty (30) calendar days prior to the effective date of the change, unless otherwise required by applicable State-specific regulatory agencies.

2. The Provider record shall be termed in Molina's core operating system (QNXT), in accordance with the applicable governing policy and procedure maintained by the PCM functional business unit.

3. If the Provider Type is other than PCP, a claims report must be generated covering the three (3) months prior to the termination date. Additionally, a Prior Authorization Log must be reviewed to capture affected membership for Member notification.

4. Member notification shall be made in accordance with the applicable governing policy and procedure maintained by the Enrollment Accounting functional business unit.

F. Provider directory updates shall be made in accordance with the applicable governing policy and procedure, cross-referenced on page 1 of this Policy and Procedure.

G. Regulatory Reporting

1. Upon notification from regulatory agencies, Molina shall create, develop and submit any new mandatory reports and/or modify existing reports to comply with all applicable State and Federal agency regulations.

2. Notify IDHW in writing of the termination of the Health Plan's Network Provider Subcontract with any hospital, whether the termination is initiated by the Hospital or by the Health Plan, no less than thirty (30) calendar days prior to the effective date of the termination.

a. Notify IDHW of any Provider termination and submit an Excel

spreadsheet that includes the Provider's name, IDHW Provider identification number, NPI number (if applicable), and the number of Enrollees affected within five (5) business days of the Provider's termination. If the termination was initiated by the Provider, the notice to IDHW shall include a copy of the Provider's notification to the Health Plan.

- b. The Health Plan shall maintain documentation of all information, including a copy of the actual Enrollee notice(s) on-site. Upon request, the Health Plan shall provide IDHW a copy of the following: one (1) or more of the actual Enrollee notices mailed, an electronic listing in Excel identifying each Enrollee to whom a notice was sent, a transition plan for the Enrollees affected, and documentation from the Health Plan's mail room or outside vendor indicating the quantity and date Enrollee notices were mailed as proof of compliance with the Enrollee notification requirements.
- c. Notify IDHW within five (5) business days of the date that the Network Provider Subcontract was terminated in writing, the terminations of all network Provider Subcontracts that cause the Health Plan to be out of compliance with The Network Adequacy Standards.
- d. Notify IDHW of significant changes that may affect Provider procedures at least thirty (30) calendar days prior to notifying its Provider network of the changes. The Health Plan shall give Providers at least thirty (30) calendar days 'advance notice of significant changes that may affect the Providers' procedures (e.g. changes in subcontractors, claims submission procedures, or prior authorization policies).
- e. The Health Plan shall post a notice of the changes on its Provider website to inform both in-network and out-of-network Providers, and make payment policies available to out-of-network Providers upon request.

- H. Molina state-level health plans are required to maintain Provider termination policies and/or Standard Operating Procedures (SOP) outlining state-specific end- to-end requirements and processes.

IV. DEFINITIONS

Significant Change – Contract termination which creates a network adequacy gap and/or affects a large number of Molina enrollees based upon network access standards by geographic type (i.e., Large Metro, Metro, Micro, Rural, CEAC).

CEAC – Counties with extreme access considerations.

Define the process and give step by step procedures and work-flows within departments and between work areas as applicable.

N/A

Policy

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks	Policy No. MHU-PS-027
Title: MHU – VP of Network Management	Policy Title: Training on Reporting Suspected Abuse of an Adult
Signature:	Department Name: Provider Services
Approval Date:	Effective Date: 1/1/18
<i>If Required:</i>	Reviewed and Revised Date: 07/17
Approver Name:	Review Only Date: 8/18
Title:	Supersedes and replaces:
Signature:	N/A
Approval Date:	

Line of business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input type="checkbox"/> Medicaid <input checked="" type="checkbox"/> ID Medicaid Plus
<input type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input type="checkbox"/> Health Insurance MarketPlace
<input type="checkbox"/> Medicare	<input type="checkbox"/> Other: CHIP
<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN

References (s): *(Identify if this policy references another policy or contract requirement.)*
 N/A

Departments identified in the policy:

Provider Services, Quality Improvement, Health Care Services, Pharmacy, Member Services, Claims and Encounter Data

Oversight Committee:

Member Provider Satisfaction Committee (MPSC)

I. PURPOSE

To establish a process for the initial and ongoing education and training of providers and practitioners. This policy sets forth the critical components and parameters of such training.

II. POLICY

Conduct on-going provider training, ensuring accuracy and consistency of all information given to providers on an ongoing basis relating to the delivery of health care. Encourage providers to engage in additional training that may be provided by State agencies.

III. DEFINITIONS

N/A

SLT Signature (*if expedited*): _____ **Date:** _____

Procedure

Health Plan: Molina Healthcare of Utah	
Approver Name: John Oaks Title: MHU – VP of Network Management Signature: Approval Date:	Procedure Title: Training on Reporting Suspected Abuse of an Adult Policy No. Reference: MHU-PS-027 Policy Title Reference: Provider Satisfaction Department Name: Provider Services
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	Effective Date: 1/1/18 Supersedes and replaces: N/A

Line of business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> ID Medicaid Plus
<input checked="" type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input checked="" type="checkbox"/> Health Insurance MarketPlace
<input checked="" type="checkbox"/> Medicare	<input type="checkbox"/> Other:
<input type="checkbox"/> LONG TERM SERVICES AND SUPPORT (LTSS)	<input checked="" type="checkbox"/> MEDICARE MEDICAID COORDINATED PLAN

I. Program Description

A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

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

1. Molina Medicare employees who have knowledge of or suspect the abuse, neglect or exploitation;
2. Law enforcement officer;

3. Social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; and/or
 4. An employee of a social service, welfare, mental /behavioral health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science Provider or healthcare provider.
 5. A permissive reporter is any individual with knowledge of a potential abuse situation who is not included in the list of mandatory reporters. A permissive reporter may report to the Molina UM Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited or neglected. Permissive or voluntary reporting will occur as needed.
- B. The following are the types of abuse which are required to be reported:
1. Physical abuse is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints.
 2. Sexual abuse is nonconsensual sexual contact. Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing.
 3. Mental/behavioral mistreatment is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; and yelling or swearing which results in mental distress.
 4. Neglect occurs when someone, either through action or inaction, deprives a vulnerable adult of care necessary to maintain physical or mental health.
 5. Self-neglect occurs when a vulnerable adult fails to provide adequately for themselves. A competent person who decides to live their life in a manner which may threaten their safety or well-being does not come under this definition.
 6. Exploitation occurs when a vulnerable adult or the resources or income of a vulnerable adult are illegally or improperly used for another person's profit or gain.
 7. Abandonment occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter or health care.

II. PROCEDURE

- A. In the event that an employee of Molina or one of its contracted providers encounters potential or suspected abuse as described above, a call must be made to:

Agency	Contact Information
Idaho's Adult Protection Office	1-800-526-8129 http://elder-abuseca.com/docs/Idaho-Adult-Protection.pdf
Attorney General 24-hour Health Care Fraud Hotline	(208) 334-2400 http://www.ag.idaho.gov/seniorCitizens/seniorCitizens_index.html
Idaho Commission on Aging	https://aging.idaho.gov/protection/elder.html 1-877-471-2777 Reporting of Elder Abuse: Call 211 or Adult Protection at your local area agency

- B. All reports should include:

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

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

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

Define the process and give step by step procedures and work-flows within departments and between work areas as applicable.

N/A

Policy

Health Plan: Molina Healthcare, Inc.	
Approver Name: Tamara Gates Title: Director, Provider Engagement Signature: _____ Approval Date: _____ See Procedure, Exhibit 1 for Health Plan Approval	Policy No. PS-54
	Policy Title: Out of Network Coverage
	Department Name: Provider Services
	Effective Date: 01/01/2016
	Reviewed and Revised Date: 04/22/2016; 07/01/2017, 8/18
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	Review Only Date:
	Supersedes and Replaces: MM-PRV-07 – Medicare Non-Participating (Non Par) Provider Agreement Process for Ancillary, Hospital Provider and Specialty Practitioners

Line of Business:

- ☒ All
- ☐ Medicare-Medicaid Programs (Duals)
- ☐ Medicare
- ☐ Medicaid and Medicaid Plus
- ☐ Health Insurance Marketplace
- ☐ Other: Medicare Medicaid Coordinated Plan (MMCP)

References (s): N/A

Departments identified in the policy: N/A

Oversight Committee: N/A

I. PURPOSE

The purpose of this policy is to outline a process to ensure members receive appropriate and timely health care services when contracted providers are not available within the Molina Healthcare provider network. In addition, Molina Healthcare's policy is to provide coverage for out-of-network emergent or urgent services, as defined by the Centers for Medicare and Medicaid Services ("CMS") and all applicable state and federal agencies.

This policy shall comply with CMS Reference Code 42 CFR 424.101 and 42 CFR 405.400, Medicare Managed Care Manual Chapter 11, Section 100.4, Medicare Marketing Guidelines.

II. POLICY

Molina Healthcare is committed to providing adequate and timely healthcare services to Members. Molina Healthcare shall ensure that Members have access to necessary health care services. If access to a Provider, for a specific service is not available within the network, or within reasonable distance from the Member's place of residence, Molina Healthcare shall authorize access to a qualified non-participating Provider.

If access to a qualified non-participating Provider is necessary, the Member's treating Provider will contact the Health Care Services Department and request an authorization for access to a non-participating Provider. The Health Care Services Department shall authorize medically necessary services to a non-participating Provider for those services not available within the network. A one-time agreement shall be negotiated with the non-participating Provider.

If the Member is in need of emergent or urgent services, and accesses an out-of-network Provider, those services are covered and will be reimbursed at the respective Medicare or Medicaid Fee-For-Service rate.

III. DEFINITIONS

N/A

SLT Signature (if expedited): _____ **Date:** _____

Procedure

Health Plan: Molina Healthcare, Inc.	
Approver Name: Tamara Gates Title: Director, Provider Engagement Signature: _____ Approval Date: _____ See Exhibit 1 for Health Plan Approval	Policy No. PS-54
	Policy Title: Out of Network Coverage
	Department Name: Provider Services
	Effective Date: 01/01/2016
	Reviewed and Revised Date: 04/22/2016; 07/01/2017
	Review Only Date: 8/18
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	Supersedes and Replaces: MM-PRV-07 – Medicare Non-Participating (Non Par) Provider Agreement Process for Ancillary, Hospital Provider and Specialty Practitioners

Line of Business:

- ☒ All
- ☐ Medicare-Medicaid Programs (Duals)
- ☐ Medicare
- ☐ Medicaid
- ☐ Health Insurance Marketplace
- ☐ Other: Medicare Medicaid Coordinated Plan (MMCP)

References (s): N/A

Departments identified in the policy: N/A

Oversight Committee: N/A

Description of process and procedure/service:

To outline a process to ensure members receive appropriate and timely health care services when contracted providers are not available within the Molina Healthcare provider network. In addition, Molina Healthcare's policy is to provide coverage for out-of-network emergent or urgent services, as defined by the Centers for Medicare and Medicaid Services (CMS) and all applicable state and federal agencies.

PROCEDURE

1. The Member's treating Provider shall contact the Health Care Services Department and request a Prior Authorization to a non-participating Provider.
2. If the network is deficient in a particular specialty type, and that specialty type is available but not contracted with Molina Healthcare, the Health Care Services Department shall identify a the specialty care Provider for the course of treatment.
3. The one-time agreement shall be negotiated by the applicable Molina Healthcare state-level health plan's contracting department. The Member will not incur additional expenses beyond what the Member would have to pay for services provided by a contracted Provider.
4. A Prior Authorization will be generated by Health Care Services allowing the Member access to a non-participating Provider within a reasonable distance and travel time for the Member.
5. Claims shall be reimbursed at the negotiated one-time agreement rate.
6. If the Member is out of the service area and in need of urgent care, the Member can access the following care from a non-participating Provider without a Prior Authorization:
 - a. Emergent
 - b. Post emergent stabilization
 - c. Urgent
 - d. The emergency care services will be paid at the respective Medicare or Medicaid Fee-For-Service rate.
7. A copy of the one-time agreement shall be retained by the Molina Healthcare state-level health plan.

ATTACHMENTS

Exhibit 1 – State Health Plan P&P Approval and Signature Log

Exhibit 1 – State Health Plan P&P Approval and Signature Log

State Health Plan	Approver Name	Approver Title	Approver Signature	Approval Date
Molina Healthcare of California				
Molina Healthcare of Florida				
Molina Healthcare of Idaho				
Molina Healthcare of Illinois				
Molina Healthcare of Michigan				
Molina Healthcare of New Mexico				
Molina Healthcare of New York				
Molina Healthcare of Ohio				
Molina Healthcare of Puerto Rico				
Molina Healthcare of South Carolina				
Molina Healthcare of Texas				
Molina Healthcare of Utah				
Molina Healthcare of Virginia				
Molina Healthcare of Washington				
Molina Healthcare of Wisconsin				

Policy

Health Plan: Molina Healthcare, Inc.	
Approver Name: Tamara Gates	Policy No. PS-56
Title: Director, Provider Engagement	Policy Title: Provider Manual
Signature: _____	Department Name: Provider Services
Approval Date: _____	Effective Date: 01/01/2016
	Reviewed and Revised Date: 07/01/2017
	Review Only Date:
See Procedure, Exhibit 1 for Health Plan Approval	Supersedes and Replaces: MM-PRV-01 – Medicare Provider Manual
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	

Line of Business:

- ☒ All
- ☐ Medicare-Medicaid Programs (Duals)
- ☐ Medicare
- ☐ Medicaid and Medicaid Plus
- ☐ Health Insurance Marketplace
- ☐ Other: Medicare Medicaid Coordinated Plan (MMCP)

References (s):

PS-61 Provider Manual Internal Audit and Validation Process

Departments Identified in the Policy: N/A

Oversight Committee: N/A

I. PURPOSE

The purpose of this policy is to provide a consistent process for disseminating essential information to all contracted Providers regarding both the provision of health care services and operations. Each Molina Healthcare state-level health plan shall develop, publish and distribute a Provider Manual to serve as a primary resource to all Molina Healthcare contracted Providers.

II. POLICY

The Provider Manual shall be developed as a tool for Providers to utilize in the delivery of health care services to Molina Healthcare Members.

The Provider Manual shall serve as a supplement to each state-level health plan's Provider Services Agreement.

The Provider Manual shall include an introduction to Molina Healthcare, its organizational and clinical philosophy, mission, vision, and governing principles. In addition, the Provider Manual content shall outline operational information in sections according to general topics.

III. DEFINITIONS

N/A

SLT Signature (if expedited): _____ **Date:** _____

Procedure

Health Plan: Molina Healthcare, Inc.	
Approver Name: Tamara Gates	Policy No. PS-56
Title: Director, Provider Engagement	Policy Title: Provider Manual
Signature: _____	Department Name: Provider Services
Approval Date: _____	Effective Date: 01/01/2016
	Reviewed and Revised Date: 07/01/2017
	Review Only Date: 8/18
See Exhibit 1 for Health Plan Approval	Supersedes and Replaces: MM-PRV-01 – Medicare Provider Manual
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	

Line of Business:

- ☒ All
☐ Medicare-Medicaid Programs (Duals)
☐ Medicare
☐ Medicaid and Medicaid Plus
☐ Health Insurance Marketplace
☐ Other: *Medicare Medicaid Coordinated Plan (MMCP)*

References (s):

PS-61 Provider Manual Internal Audit and Validation Process

Departments Identified in the Policy: N/A

Oversight Committee: N/A

Description of process and procedure/service:

To provide a consistent process for disseminating essential information to all contracted Providers regarding both the provision of health care services and operations. Each Molina Healthcare state-level health plan shall develop, publish and distribute a Provider Manual to serve as a primary resource to all Molina Healthcare contracted Providers.

PROCEDURE

Each Molina Healthcare state-level health plan shall be responsible for the development, maintenance and distribution of the Provider Manual.

A. Development of Provider Manual Information.

The Provider Manual shall be designed to include Molina Healthcare corporate policies, procedures, protocols, forms and other information required for providers to operate and comply with the contractual terms and conditions of their Provider Services Agreement with Molina Healthcare. The Provider Manual shall be a compilation of information from pertinent functional business units and/or departments within Molina Healthcare, as well as key outside sources, such as the Centers for Medicare and Medicaid Services (CMS) and all applicable State and Federal regulations.

1. For Molina Healthcare New Market Developments, MHI Provider Services will develop the Provider Manual templates for all applicable lines of business.

B. Maintenance of Provider Manual Information.

1. The Provider Manual shall be reviewed on a continuous basis to ensure accuracy of current contents and to ensure that new policies, procedures, protocols and forms are updated.
2. An update to the Provider Manual shall include pertinent additions, deletions or changes to a policy, procedure, protocol or form. The appropriate Provider Manual sections shall be sent electronically via e-mail to the Molina Healthcare pertinent functional business units and/or departments on an as-needed basis, or annually, at a minimum, for the revision and/or updating of the information.
3. It shall be the responsibility of the pertinent functional business units and/or departments to collaborate with the Provider Services to ensure that updates are included in the next Provider Manual update cycle.
4. For the Marketplace and Medicare Provider Manuals, MHI Provider Services shall compile all updates received, make the necessary revisions and coordinate the uploading of the Provider Manual to the appropriate Molina Healthcare websites/provider portal as appropriate.
5. For other Molina Healthcare Provider Manuals, Molina Healthcare state-level health plans shall compile updates, make the necessary revisions and coordinate the uploading of the Provider Manual to their state-level health plan website/provider portal as appropriate.

C. Distribution of Provider Manual

1. **New Provider.** The Molina Healthcare state-level Provider Services and/or Contracting department shall make the most current Provider Manual available to a new provider at the time of contract execution.
2. **Annual Review.** The Molina Healthcare Provider Manuals shall be reviewed and updated on an annual basis and made available on the Molina Healthcare state-level health plan website/provider portal as appropriate

ATTACHMENTS

Exhibit 1 – State Health Plan P&P Approval and Signature Log
Exhibit 2 – Medicaid, Dual/MMP, MEDICARE MEDICAID COORDINATED PLAN Provider Manual Language Update Workflow
Exhibit 3 – Medicare Provider Manual Language Update Workflow
Exhibit 4 – Marketplace Provider Manual Language Update Workflow
Exhibit 5 – New Markets Provider Manual Language Update Workflow

Exhibit 1 – State Health Plan P&P Approval and Signature Log

State Health Plan	Approver Name	Approver Title	Approver Signature	Approval Date
Molina Healthcare of California				
Molina Healthcare of Florida				
Molina Healthcare of Idaho				
Molina Healthcare of Illinois				
Molina Healthcare of Michigan				
Molina Healthcare of New Mexico				
Molina Healthcare of New York				
Molina Healthcare of Ohio				
Molina Healthcare of Puerto Rico				
Molina Healthcare of South Carolina				
Molina Healthcare of Texas				
Molina Healthcare of Utah				
Molina Healthcare of Virginia				
Molina Healthcare of Washington				
Molina Healthcare of Wisconsin				

Exhibit 2 – Medicaid, Dual/MMP, MEDICARE MEDICAID COORDINATED PLAN Provider Manual Language Update Workflow

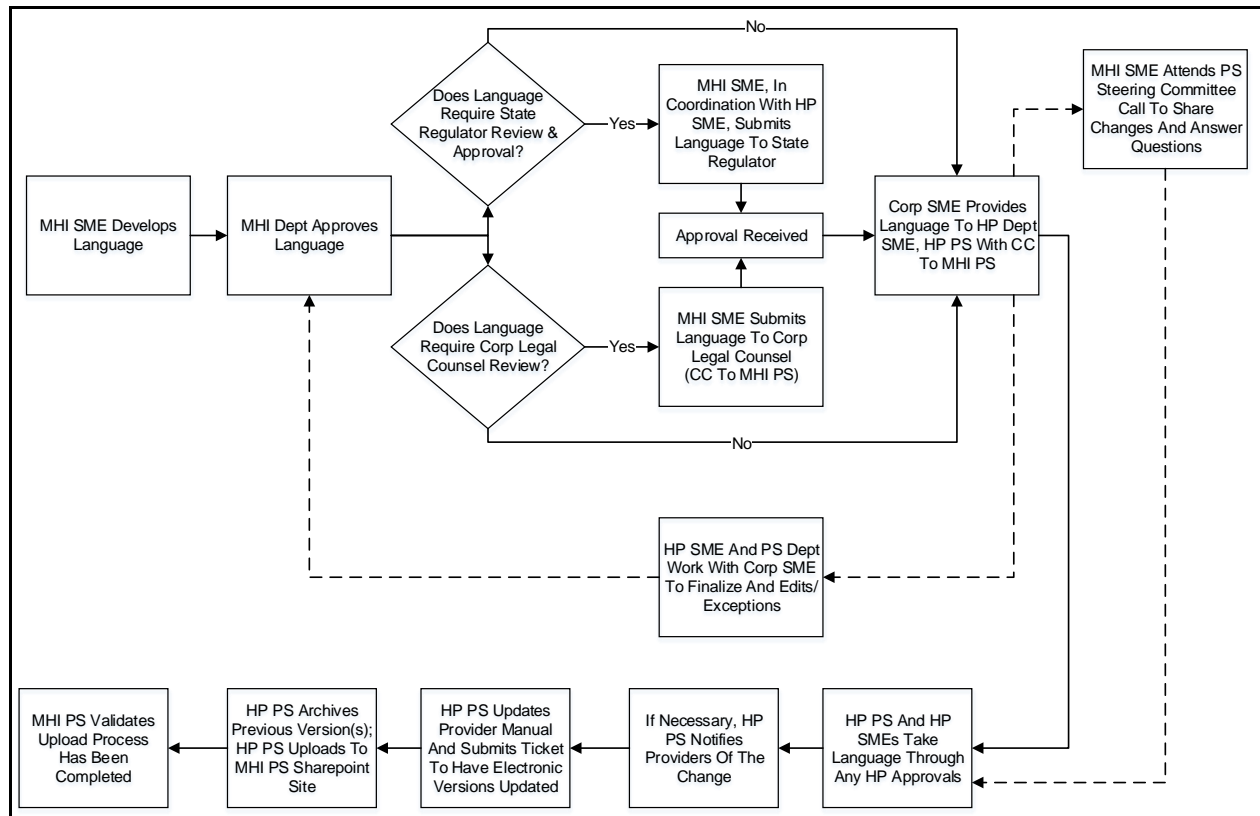


Exhibit 3 – Medicare Provider Manual Language Update Workflow

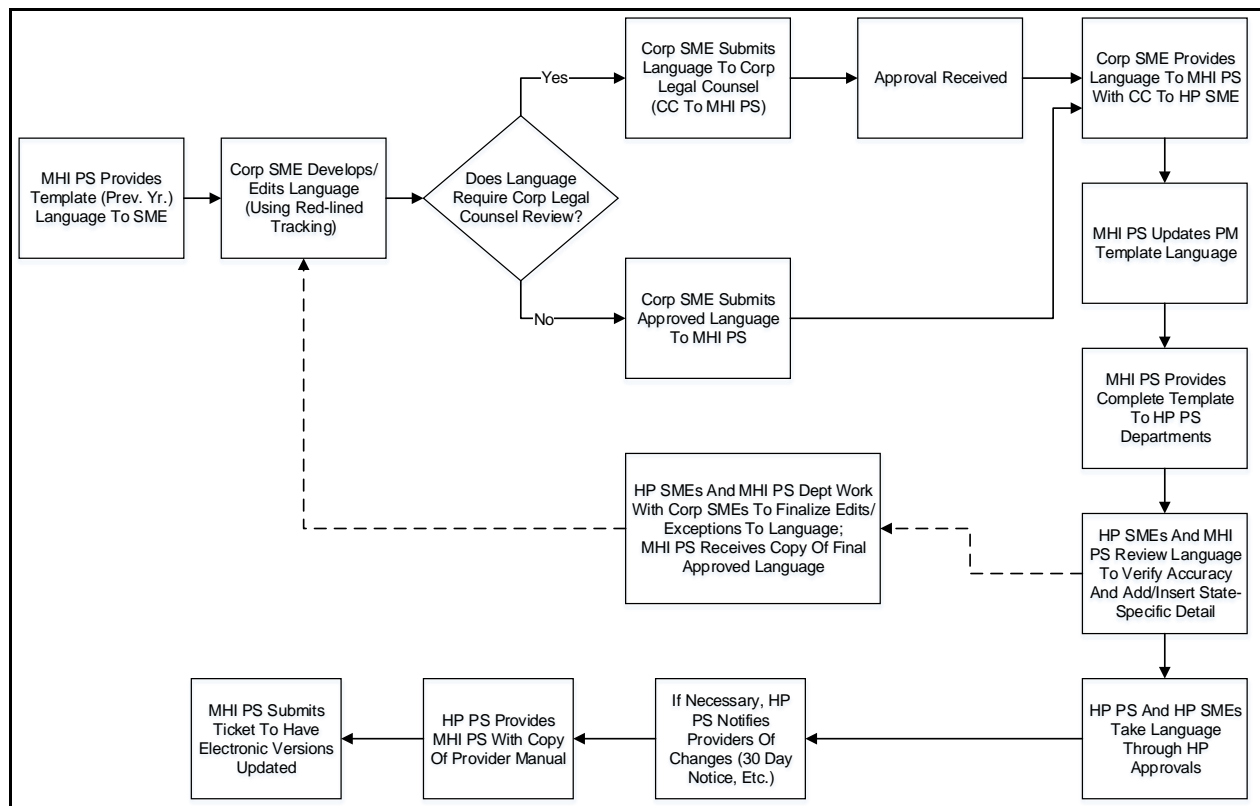


Exhibit 4 – Marketplace Provider Manual Language Update Workflow

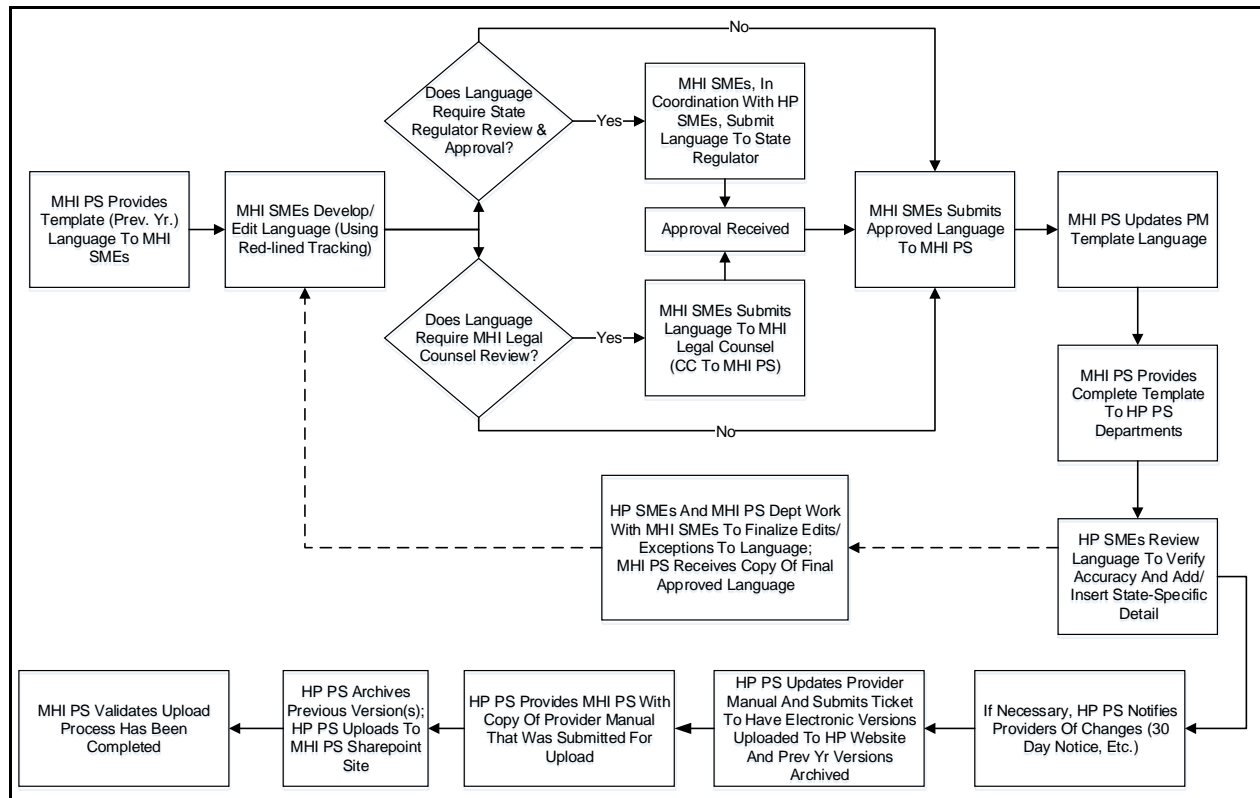
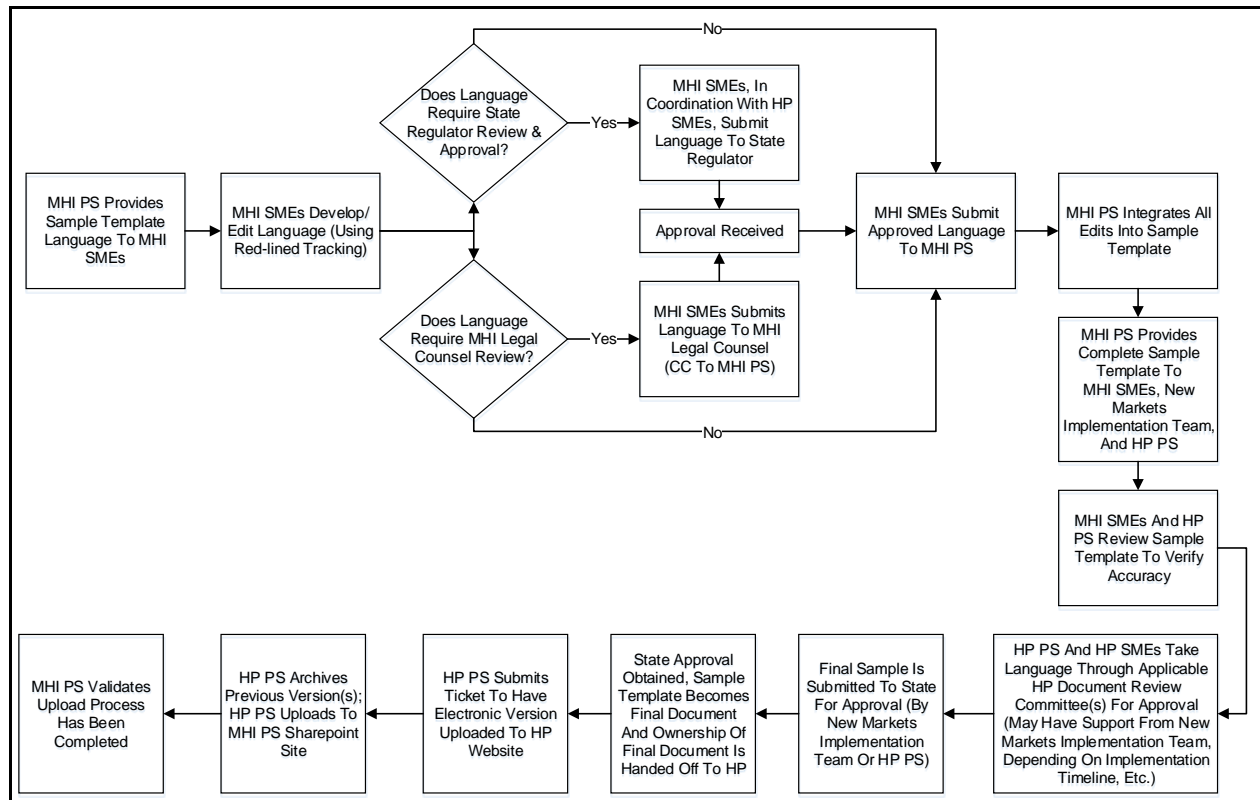


Exhibit 5 – New Markets Provider Manual Language Update Workflow



Policy

Health Plan: Molina Healthcare, Inc.	
Approver Name: Tamara Gates Title: Director, Provider Engagement	Policy No. PS-57
Signature: _____	Policy Title: Policy and Procedure Guidelines and Annual Review Requirements
Approval Date: _____	Department Name: Provider Services
See Procedure, Exhibit 1 for Health Plan Approval	Effective Date: 01/01/2016
	Reviewed and Revised Date: 07/01/2017
	Review Only Date: 8/18
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	Supersedes and Replaces:

Line of Business:

- ☒ All
- ☐ Medicare-Medicaid Programs (Duals)
- ☐ Medicare
- ☐ Medicaid and Medicaid Plus
- ☐ Health Insurance Marketplace
- ☐ Other: Medicare Medicaid Coordinated Plan (MMCP)

References (s): N/A

Departments identified in the policy: N/A

Oversight Committee: N/A

I. PURPOSE

The purpose of this policy is to establish a process to manage and review policies and procedures (P&P) and standards for writing P&Ps for Molina Healthcare Corporate Provider Services.

II. POLICY

Molina Healthcare Corporate Provider Services shall utilize the specified format and procedure when writing, reviewing, updating and posting P&Ps.

P&Ps shall be maintained as required by Molina Healthcare, the Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA) and all applicable State and Federal regulations.

P&Ps shall be housed in a central location on the Molina Healthcare Corporate Provider Services SharePoint Site.

P&Ps shall be signed and executed by only the director level or above, or as otherwise delegated.

Review of the P&Ps shall occur on an as-needed basis, or annually, at a minimum.

III. DEFINITIONS

N/A

SLT Signature (if expedited): _____ **Date:** _____

Procedure

Health Plan: Molina Healthcare, Inc.	
Approver Name: Tamara Gates Title: Director, Provider Engagement	Policy No. PS-57
Signature: _____	Policy Title: Policy and Procedure Guidelines and Annual Review Requirements
Approval Date: _____	Department Name: Provider Services
See Exhibit 1 for Health Plan Approval	Effective Date: 01/01/2016
	Reviewed and Revised Date: 07/01/2017
	Review Only Date: 8/18
<i>If Required:</i> Approver Name: Title: Signature: Approval Date:	Supersedes and Replaces:

Line of Business:

- ☒ All
- ☐ Medicare-Medicaid Programs (Duals)
- ☐ Medicare
- ☐ Medicaid and Medicaid Plus
- ☐ Health Insurance Marketplace
- ☐ Other: Medicare Medicaid Coordinated Plan (MMCP)

References (s): N/A

Departments identified in the policy: N/A

Oversight Committee: N/A

Description of process and procedure/service:

To establish a process to manage and review policies and procedures (“P&P”) and standards for writing P&Ps for Molina Healthcare Corporate Provider Services.

PROCEDURE

A. Drafting and Revising

1. When drafting and/or revising P&Ps, naming conventions that include entity abbreviation, department name abbreviation and P&P number (e.g., EAC-001) shall be utilized. See Exhibit 1.
2. P&Ps should be free of spelling and typographical errors.
3. P&Ps to the extent possible should be inclusive of all lines of business.
4. There shall be no separate numbering scheme for all attachments and exhibits; all attachments and exhibit pages shall be numbered as pages of the P&P document.
5. When referring to a report, a sample of said report shall be provided.
6. P&Ps shall set forth all information for full implementation.

B. Revisions

1. Every P&P shall be reviewed annually, at a minimum. P&Ps affected by a more frequent update shall be updated as necessary within no more than thirty (30) business days as of the effective date of the applicable CMS, NCQA, state or federal regulatory requirement.
2. The “Track Changes” function in Microsoft Word shall be utilized to create a redlined version of the P&P being updated.
3. Revised (redlined) versions of P&Ps shall be stored in the Molina Healthcare Corporate Provider Services sharepoint site.

C. Effective Date

1. The effective date of each policy and procedure shall be the original date the P&P was implemented.
2. The “Reviewed Only” and “Review and Revised” sections shall be utilized to indicate more recent dates.
3. Signed date shall be utilized to indicate the date of execution.

D. Molina State-Level Health Plan Review and Sign-Off

1. Corporate Provider Services shall distribute P&Ps Molina State-Level Health Plans for review and sign-off as applicable.
2. P&Ps shall be signed and executed by director level or above, or as otherwise delegated and returned to Corporate Provider Services.

E. Adding to Centralized Library

1. P&Ps (and related attachments) shall be posted to the Molina Healthcare Corporate Provider Services sharepoint site.

ATTACHMENTS

Exhibit 1 – State Health Plan P&P Approval and Signature Log

Exhibit 2 – Policy Form 2016

Exhibit 3 – Procedure Form 2016

Exhibit 1 – State Health Plan P&P Approval and Signature Log

State Health Plan	Approver Name	Approver Title	Approver Signature	Approval Date
Molina Healthcare of California				
Molina Healthcare of Florida				
Molina Healthcare of Idaho				
Molina Healthcare of Illinois				
Molina Healthcare of Michigan				
Molina Healthcare of New Mexico				
Molina Healthcare of New York				
Molina Healthcare of Ohio				
Molina Healthcare of Puerto Rico				
Molina Healthcare of South Carolina				
Molina Healthcare of Texas				
Molina Healthcare of Utah				
Molina Healthcare of Virginia				
Molina Healthcare of Washington				
Molina Healthcare of Wisconsin				

Exhibit 2 – Policy Form



Policy

Health Plan:	
Approver Name:	Policy No.
Title:	Policy Title:
Signature:	Department Name:
Approval Date:	Effective Date:
<i>If Required:</i>	Reviewed and Revised Date:
Approver Name:	Review Only Date:
Title:	Supersedes and replaces: <i>(Policy No. and Title Being Replaced)</i>
Signature:	
Approval Date:	

Line of Business: <i>(Please click all that apply)</i>	
<input type="checkbox"/> All	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Medicare-Medicaid Programs (Duals)	<input type="checkbox"/> Health Insurance Marketplace
<input type="checkbox"/> Medicare	<input type="checkbox"/> Other: _____

References (s): *(Identify if this policy references another policy or contract requirement.)*

Enter text here (Type N/A if needed)

Departments identified in the policy:

Enter text here (Type N/A if needed)

Oversight Committee:

Enter text here (Type N/A if needed)

IV. PURPOSE

Enter text here

V. POLICY

Enter text here

VI. DEFINITIONS

Enter text here (Type N/A if needed)

SLT Signature *(if expedited):* _____

Date: _____

Exhibit 3 – Procedure Form



Procedure

Health Plan:	
Approver Name:	Procedure Title:
Title:	Policy No. Reference:
Signature:	Policy Title Reference:
Approval Date:	Department Name:
<i>If Required:</i>	Effective Date:
Approver Name:	Supersedes and replaces: <i>(Policy No. and Title Being Replaced)</i>
Title:	
Signature:	
Approval Date:	

Line of Business: *(Please click all that apply)*

- | | |
|---|---|
| <input type="checkbox"/> All | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Medicare-Medicaid Programs (Duals) | <input type="checkbox"/> Health Insurance Marketplace |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Other: _____ |

Description of process and procedure/service:

Enter text here

Define the process and give step by step procedures and work -flows within departments and between work areas as applicable.

Enter text here