Section 1. Addresses and Phone Numbers

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding member claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and member complaints. Member Services Representatives are available 8:00 a.m.-6:00 p.m. CT Monday through Friday, excluding State holidays.

Member Services	
Address:	Molina Healthcare of Texas, Inc. 5605 N. MacArthur Blvd., Suite 400 Irving, TX 75038
Phone:	1-888-560-2025
TTY/TDD	1-800-735-2989

Claims Department

The Claims Department is located at our corporate office in Long Beach, CA. All hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address listed below. Electronically filed claims must use Payor ID number 20554. To verify the status of your claims, please call our Provider Claims Representatives at the numbers listed below:

Claims	
Address	Molina Healthcare of Texas, Inc. PO BOX 22719 Long Beach, CA 90801
Phone:	1-855-322-4080

Claims Recovery Department

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

Claims Recovery	
Address	Molina Healthcare of Texas, Inc. PO Box 22719 Long Beach, CA 90801
Phone:	1-855-322-4080

Credentialing Department

The Credentialing Department verifies all information on the Practitioner Application prior to contracting and re-verifies this information every three years. The information is then presented to the Credentialing Committee to evaluate a provider's qualifications to participate in the Molina Healthcare network.

Credentialing	
Address:	Molina Healthcare of Texas, Inc. 84 NE Loop 410 #200
Phone: 203043	1- 877-665-4622 x 203141, or
Fax:	210-525-0576

24-Hour Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Healthcare members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available (24) hours a day, seven (7) days a week to assess symptoms and help make good health care decisions.

HEALTHLINE (24-Hour Nurse Advice Line)	
English Phone:	(888) 275-8750
Spanish Phone:	(866) 648-3537
TTY:	(866) 735-2929 (English) (866) 833-4703 (Spanish)

Healthcare Services (UM) Department

The Healthcare Services (formerly UM) Department conducts concurrent review on inpatient cases and processes Prior Authorization requests. The Healthcare Services (HCS) Department also performs Case Management for members who will benefit from Case Management services.

Healthcare Services Authorizations & Inpatient Census	
Address:	Molina Healthcare of Texas, Inc. 5605 Mac Arthur Blvd. Suite 400 Irving, Texas 75038
Phone:	1-855-322-4080
Fax:	1-866-420-3639

Health Education & Health Management Department

The Health Education and Health Management Department provides education and health information to Molina Healthcare members and facilitates provider access to the programs and services.

Health Education & Management	
Address:	Molina Healthcare of Texas, Inc. 5605 N. MacArthur Blvd., Suite 400 Irving, TX 75038

Phone:	1-866-472-9483

Behavioral Health

Molina Healthcare of Texas, Inc. manages all components of our covered services for behavioral health. For member behavioral health needs, please contact us directly at:

Behavioral Health	
Address:	Molina Healthcare of Texas, Inc. 5605 N. MacArthur Blvd., Suite 400 Irving, TX 75038
Phone:	1-800-818-5837
(24) Hours per day, (365) day per year: 1-888-275-8750	

Pharmacy Department

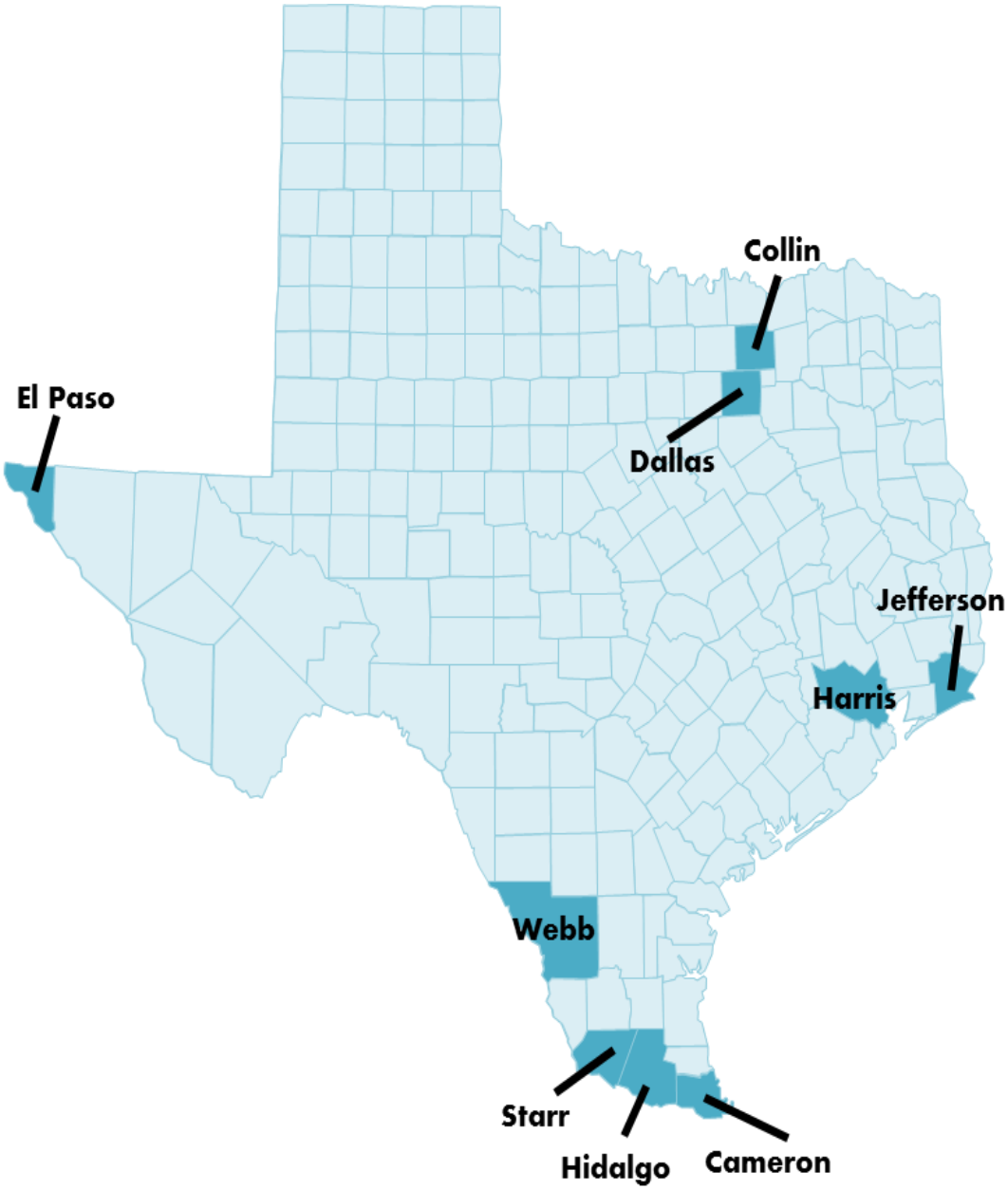
Prescription drugs are covered by Molina Healthcare, via our pharmacy vendor, CVS Caremark. A list of in-network pharmacies is available on the molinaheathcare.com website, or by contacting Molina Healthcare at 1-855-322-4080

Provider Services Department

The Provider Services Department handles telephone and written inquiries from providers regarding address and Tax-ID changes, provider denied claims review, contracting, and training. The department has Provider Services Representatives who serve all of Molina Healthcare of Texas's provider network.

Provider Services	
Address:	Molina Healthcare of Texas, Inc. 5605 MacArthur Blvd., Suite 400 Irving, TX 75038
Phone:	855-322-4080
Fax:	281-599-8916

Molina Healthcare of Texas, Inc. Service Area



Section 2. Enrollment, Eligibility and Disenrollment

Enrollment

Enrollment in Texas Molina Marketplace Program

The Molina Marketplace is the program which implements the Health Insurance Marketplace as part of the Affordable Care Act. It is administered by the Federally Facilitated Market place (FFM).

To enroll with Molina Healthcare, the member, his/her representative, or his/her responsible parent or guardian must follow enrollment process established by Federally Facilitated Marketplace will enroll all eligible members with the health plan of their choice.

No eligible member shall be refused enrollment or re-enrollment, have his/her enrollment terminated, or be discriminated against in any way because of his/her health status, pre-existing physical or mental condition, including pregnancy, hospitalization or the need for frequent or high-cost care.

Effective Date of Enrollment

Coverage shall begin as designated by the Marketplace Exchange on the first day of a calendar month. If the enrollment application process is completed by the 15th of the month, the coverage will be effective on the first day of the next month. If enrollment is completed after the 15th of the month, coverage will be effective on the first day of the second month following enrollment.

Newborn Enrollment

When a Molina Healthcare Marketplace Subscriber or their Spouse gives birth, the newborn is automatically covered under the Subscriber's policy with Molina Healthcare for the first 31 days of life. In order for the newborn to continue with Molina Healthcare coverage past this time, the infant must be enrolled through the Marketplace Exchange with Molina Healthcare on or before 60 days from the date of birth.

PCP's are required to notify Molina Healthcare via the Pregnancy Notification Report (included in Appendix B of this manual) immediately after the first prenatal visit and/or positive pregnancy test for any Molina Healthcare member presenting themselves for healthcare services.

Inpatient at time of Enrollment

Regardless of what program or health plan the member is enrolled in at discharge, the program or plan the member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the member is no longer confined to an acute care hospital.

Eligibility Verification

Health Insurance Marketplace Programs

Payment for services rendered is based on enrollment status and coverage selected. The

contractual agreement between providers and Molina Healthcare places the responsibility for eligibility verification on the provider of services.

Eligibility Listing for Molina Healthcare Marketplace Programs

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

- Molina Healthcare Member Services at (855)322-4080 ,
- Molina Healthcare, Inc.Web Portal website, www.molinahealthcare.com, Provider Services

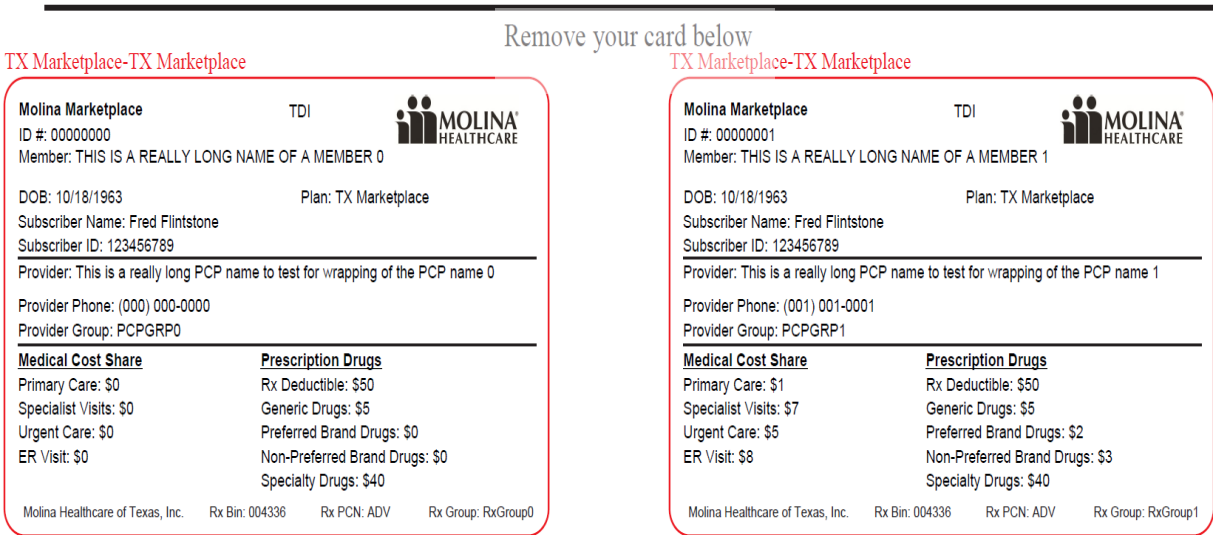
Providers will also be able to verify if the Members receiving the Advanced Payment of the Premium Tax Credit (APTC) are in the grace period.

Possession of a Marketplace ID Card does not mean a recipient is eligible for Marketplace services. A provider should verify a recipient's eligibility each time the recipient presents to their office for services.

Identification Cards

Molina Healthcare of Texas, Inc. Sample Member ID card

Card Front



SAMPLE

Card Back


TX Marketplace-TX Marketplace

This card is for identification purposes only and does not prove eligibility for service.
Member: Emergencies (24 hrs): when a medical emergency might lead to disability or death, call 911 immediately or get to the nearest emergency room. No prior authorization is required for emergency care.
Miembro: Emergencias (24 horas): cuando una emergencia puede resultar en muerte o disabilidad, llame al 911 imediatamente o vaya a la sala de emergencia mas cercana. No requiere autorización para servicios de emregencia.
Remit claims to: Molina Healthcare, P.O. Box 22719, Long Beach, CA 90801
Customer Support Number: (888)123-4567
24 Hour Nurse Advice Line: (800)000-0000
Para Enfermera En Español: (866) 648-3537
CVS Caremark Pharmacy Help Desk:
Provider: Notify the health plan within 24 hours of any inpatient admission at the hospital admission notification phone number.
Prior Authorization/Notification of Hospital Admission and Covered Services:
(855) 322-4080

MHO01012014 - MHO-1366 www.MolinaHealthcare.com


TX Marketplace-TX Marketplace

This card is for identification purposes only and does not prove eligibility for service.
Member: Emergencies (24 hrs): when a medical emergency might lead to disability or death, call 911 immediately or get to the nearest emergency room. No prior authorization is required for emergency care.
Miembro: Emergencias (24 horas): cuando una emergencia puede resultar en muerte o disabilidad, llame al 911 imediatamente o vaya a la sala de emergencia mas cercana. No requiere autorización para servicios de emregencia.
Remit claims to: Molina Healthcare, P.O. Box 22719, Long Beach, CA 90801
Customer Support Number: (888)123-4567
24 Hour Nurse Advice Line: (800)000-0000
Para Enfermera En Español: (866) 648-3537
CVS Caremark Pharmacy Help Desk:
Provider: Notify the health plan within 24 hours of any inpatient admission at the hospital admission notification phone number.
Prior Authorization/Notification of Hospital Admission and Covered Services:
(855) 322-4080

MHO01012014 - MHO-1366 www.MolinaHealthcare.com

Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the provider's responsibility to ensure Molina Healthcare members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an emergency condition exists, providers may refuse service if the member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

Members have the right to terminate coverage for any reason at any time. However, beyond the open-enrollment period, if a member elects to terminate coverage with Molina Healthcare

Marketplace, they are not eligible to re-enroll with another health plan until the following year's open-enrollment period unless there is a life event, and they qualify for a SEP (Special Enrollment Period) or if they are American Indian or Alaska Native. Members may discontinue Molina coverage by calling Molina Member Services at 1-(888) 560-2025.

Voluntary disenrollment does not preclude members from filing a grievance with Molina Healthcare for incidents occurring during the time they were covered.

Involuntary Disenrollment

Under very limited conditions and in accordance with the Marketplace Exchange guidelines, members may be involuntarily disenrolled from a Molina Healthcare Marketplace program. With proper written documentation and approval by MHI Enrollment Accounting or its Agent; the following are acceptable reasons for which Molina Healthcare may submit Involuntary Disenrollment requests to MHI Enrollment Accounting:

- Delinquency of payment, past defined grace period(s)
- Member has moved out of the Service Area
- Member death
- Member's continued enrollment seriously impairs the ability to furnish services to this member or other members
- Member demonstrates a pattern of disruptive or abusive behavior that could be construed as non-compliant and is not caused by a presenting illness (this may not apply to members refusing medical care)
- Member's utilization of services is fraudulent or abusive

Missed Appointments

The provider will document appointments missed and/or canceled by the member. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a provider's panel. Such a request must be submitted at least sixty (60) calendar days prior to the requested effective date. The provider agrees not to charge a member for missed appointments.

PCP Assignment

Molina Healthcare will offer each member a choice of PCPs. After making a choice, each member will have a single PCP. Molina Healthcare will assign a PCP to those members who did not choose a PCP at the time of Molina Healthcare selection. Molina Healthcare will take into consideration the member's last PCP (if the PCP is known and available in Molina Healthcare's contracted network), closest PCP to the member's home address, ZIP code location, keeping Children/Adolescents within the same family together, age (adults versus Children/Adolescents) and gender (OB/GYN). Molina Healthcare will allow pregnant members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP.

PCP Changes

Members can change their PCP at any time. All changes completed by the 25th of the month will be in effect on the first day of the following calendar month. Any changes requested on or after the 26th of the month will be in effect on the first day of the second calendar month.

Section 3. Member Rights and Responsibilities

This section explains the rights and responsibilities of Molina Healthcare members as written in the Molina Evidence of Coverage. Texas law requires that health care providers or health care facilities recognize member rights while they are receiving medical care and that members respect the health care provider's or health care facility's right to expect certain behavior on the part of patients.

Below are the Member Rights and Responsibilities:

Molina Healthcare Member Rights & Responsibilities Statement

These rights and responsibilities are posted on the Molina Healthcare web site: www.molinahealthcare.com.

Your Rights

You have the right to:

Be treated with respect and recognition of Your dignity by everyone who works with Molina Healthcare.

Get information about Molina Healthcare, our practitioners and providers, our doctors, our services and Members' rights and responsibilities.

Choose Your "main" doctor from Molina Healthcare's list of Participating Providers (This doctor is called Your Primary Care Doctor or Personal Doctor).

Be informed about Your health. If You have an illness, You have the right to be told about all treatment options regardless of cost or benefit coverage. You have the right to have all Your questions about Your health answered.

Help make decisions about Your health care. You have the right to refuse medical treatment.

You have a right to Privacy. We keep Your medical records private.*

See Your medical record. You also have the right to get a copy of and correct Your medical record where legally allowed.*

Complain about Molina Healthcare or Your care. You can call, fax, e-mail or write to Molina Healthcare's Customer Support Center.

Appeal Molina Healthcare's decisions. You have the right to have someone speak for You during Your grievance.

Disenroll from Molina Healthcare (leave the Molina Healthcare product).

Ask for a second opinion about Your health condition.

Ask for someone outside Molina Healthcare to look into therapies that are Experimental or Investigational.

Decide in advance how You want to be cared for in case You have a life-threatening illness or injury.

Get interpreter services on a 24 hour basis at no cost to help You talk with Your doctor or with us if You prefer to speak a language other than English.

Get information about Molina Healthcare, Your providers, or Your health in the language You prefer.

Ask for and get materials in other formats such as, larger size print, audio and Braille upon request and in a timely fashion appropriate for the format being requested and in accordance with state laws.

Receive instructions on how You can view online, or request a copy of, Molina Healthcare's non-proprietary clinical and administrative policies and procedures.

Get a copy of Molina Healthcare's list of approved drugs (Drug Formulary) on request.

Submit a grievance if You do not get Medically Necessary medications after an Emergency visit at one of Molina Healthcare's contracted hospitals.

Not to be treated poorly by Molina Healthcare or Your doctors for acting on any of these rights.

Make recommendations regarding Molina Healthcare's Member rights and responsibilities policies.

Be free from controls or isolation used to pressure, punish or seek revenge.

File a grievance or complaint if You believe Your linguistic needs were not met by Molina Healthcare.

*Subject to State and Federal laws

Your Responsibilities

You have the responsibility to:

Learn and ask questions about Your health benefits. If You have a question about Your benefits, call toll-free at 1 (888) 560-2025.

Give information to Your doctor, provider, or Molina Healthcare that is needed to care for You.

Be active in decisions about Your health care.

Follow the care plans and instructions for You that You have agreed on with Your doctor(s).

Build and keep a strong patient-doctor relationship. Cooperate with Your doctor and staff. Keep appointments and be on time. If You are going to be late or cannot keep Your appointment, call Your doctor's office.

Give Your Molina Healthcare card when getting medical care. Do not give Your card to others. Let Molina Healthcare know about any fraud or wrong doing.

Understand Your health problems and participate in developing mutually agreed-upon treatment goals as You are able.

Be Active In Your Healthcare

Plan Ahead

Schedule Your appointments at a good time for You

Ask for Your appointment at a time when the office is least busy if You are worried about waiting too long

Keep a list of questions You want to ask Your doctor

Refill Your prescription before You run out of medicine

Make the Most of Doctor Visits

Ask Your doctor questions

Ask about possible side effects of any medication prescribed

Tell Your doctor if You are drinking any teas or taking herbs. Also tell Your doctor about any vitamins or over–the-counter medications You are using

Visiting Your Doctor When You are Sick

- Try to give Your doctor as much information as You can.

Are You getting worse or are Your symptoms staying about the same?

Have You taken anything?

If You would like more information, please call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-2025. We are here Monday through Friday, between 8:00 a.m. and 6:00 p.m. CT.

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Second opinions

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

Section 4. Benefits and Covered Services

Molina Healthcare covers the services described in the Summary of Benefits and Evidence of Coverage (EOC) documentation for each Molina Marketplace plan type. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina Healthcare at **855-322-4080**. (M-F 8:00 a.m. - 6:00 p.m. CT)

Member Cost Sharing:

Cost Sharing is the Deductible, Copayment, or Coinsurance that members must pay for Covered Services provided under their Molina Marketplace plan. The Cost Sharing amount members will be required to pay for each type of Covered Service is summarized on the member's ID card. Additional detail regarding cost sharing listed in the Benefits and Coverage Guide located in the EOC. Cost Sharing applies to all covered services except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act). Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible members, ad determined by Marketplace's rules.

It is the provider's responsibility to collect the copayment and other member Cost Share from the member to receive full reimbursement for a service. The amount of the copayment and other Cost Sharing will be deducted from the Molina Healthcare payment for all claims involving Cost Sharing.

Links to Summaries of Benefits:

The following web link provides access to the Summary of Benefits guides for the 2014 Molina Marketplace products offered in Texas.

www.MolinaHealthcare.com

Links to Evidence of Coverage:

Detail information about benefits and services can be found in the 2014 Evidence of Coverage booklets made available to registered Molina Marketplace members and providers.

Providers may access the Evidence of Coverage booklets for the 2014 Molina Marketplace products offered in Texas via the Molina Provider Web Portal.

www.MolinaHealthcare.com

Obtaining Access to Certain Covered Services:

Prescription drugs

Prescription drugs are covered by Molina Healthcare, via our pharmacy vendor, CVS Caremark. A list of in-network pharmacies is available on the molinaheathcare.com website, or by contacting Molina Healthcare. Members must use their Molina Healthcare ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, and its limitations, is available by contacting Molina Healthcare at 855-322-4080 or at www.molinahealthcare.com.

Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases they will be made available through Molina Healthcare's vendor, Caremark

Specialty Pharmacy. More information about our Prior Authorization process, including a PA request form, is available in Section 7 of this manual.

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

Access to Behavioral Health Services

Members in need of Behavioral Health Services can be referred by their PCP for services or members can self-refer by calling Molina Healthcare of Texas Behavioral Health Department at **1-800-818-5837.** Molina Healthcare is available 24 hours a day, 7 days a week for behavioral health needs. The services members receive will be confidential. Additional detail regarding covered services and any limitations can be obtained in the EOCs linked above, or by contacting Molina Healthcare.

Emergency Behavioral Health Services

Members are directed to call "911" or go to the nearest emergency room if they need emergency behavioral health services. Examples of emergency behavioral health problems are:

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

Out of Area Emergencies

Members having a behavioral health emergency who cannot get to a Molina Healthcare approved providers are directed to do the following:

- Go to the nearest hospital or facility
- Call the number on ID card
- Call member's PCP and follow-up within (24) to (48) hours

For out-of-area emergency care, plans will be made to transfer Members to an in-network facility when member is stable.

Obtaining Behavioral Health Services

Members and Providers should call Member Services or the Behavioral Health Department to find a behavioral health provider.

Emergency Transportation

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

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Non-Emergency Transportation

Molina Healthcare provides coverage for non-emergency transportation for Molina Marketplace Silver plan members who meet certain requirements. **To find out if this is a covered service for your patient, please contact Molina Healthcare at 855-322-4080**

Non-Emergency Medical Transportation

For Molina Marketplace members who have non-emergency medical transportation as a covered service, Molina Healthcare covers transportation to medical facilities when the member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, air, etc.). This requires a written prescription from the member's doctor. Examples of non-Emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. Members must have Prior Authorization from Molina Healthcare for these services before the services are given. Additional information regarding the availability of this benefit is available by contacting Customer Service at 855-322-4080.

Non-Emergency Non-Medical Transportation

Non-Emergency non-medical transportation is available to members who have non-emergency transportation as a covered service and are recovering from serious injury or medical procedure that prevents them from driving to a medical appointment. The member must have no other form of transportation available. Prior Authorization is required to access these services. A Physician (PCP or Specialist) confirmation that member require non-Emergency non-medical transportation to and from an appointment on a specified date. Additional information regarding the availability of this benefit is available by contacting Customer Services at 855-322-4080

Non-Emergency non-medical transportation for Members to medical services can be supplied by a passenger car, taxi cabs, or other forms of public/private transportation. Members are instructed to call the transportation vendor at least two to three working days before the appointment to arrange this transportation.

Preventive Care

Molina Marketplace utilizes the following Preventive Health Guidelines for our members:

Child (birth – 17 years)

Preventive Health Guidelines

Immunizations/ Vaccines	Guidelines
DTaP/Tdap (Diphtheria, Tetanus Toxoids and acellular Pertussis)	**DTaP: 5 dose series** at ages 2 mo, 4 mo, 6 mo, 15-18 mo, and 4-6 years. May give dose #4 as early as age 12 months if 6 months have passed since dose #3. **Tdap (booster):** One time dose for children and adolescents ages 7 years and older who did not receive Tdap, then Td booster dose every 10 years thereafter. **California Law, Assembly Bill 354: Immunization Requirement** ▪ Required to receive 1 dose of Tdap vaccine on or after the 10th birthday. ▪ All students entering the 7th grade require a proof of a Tdap booster shot before entering school. ▪ Applies to all public and private schools.
HepA (Hepatitis A)	**2 dose series** to children 1 year of age (between 12 to 23 months of age). Doses given at least 6 months apart and at minimum age of 12 months.
HepB (Hepatitis B)	**3 dose series** at birth, ages 1 to 2 and 6 to18months. If not vaccinated at birth, 3 dose series given at 0, 1, and 6 months.
Hib (Haemophilus influenza type b)	**4 dose series** at ages 2 mo, 4 mo, 6 mo, 12-15 mo (booster dose). **3 dose series** at ages 2 mo, 4 mo, 12-15 mo (booster dose). Catch-up vaccine is not recommended for age 5 years and older.
HPV (Human Papillomavirus)	**3 dose series** (either HPV4 or HPV2) to females at ages 11-12 years (dose #2 given, 2 months after the first dose and dose #3 given 6 months after the first dose). Minimum age to start the series is 9 years. Recommended for females aged 13-26 years of age who have not been previously vaccinated. 3 dose series (HPV4) is recommended for males aged 11-12 years; catch-up vaccinations at ages 13-21.
IPV (Inactivated Poliovirus)	**4 dose series** at ages 2 mo, 4 mo, 6-18 mo, and 4-6 years. Minimum age to start the series is 6 weeks. Final dose should be given on or after the 4th birthday and at least 6 months from the previous one.
Flu (Influenza)	**Annually** during flu season for ages 6 months and older. For first-time vaccines: administer 2 doses for ages 6months to 8 years (≥4 weeks apart between doses). Minimum age for inactivated influenza vaccine (IIV) is 6 months. Minimum age for live attenuated influenza vaccine (LAIV) is 2 years.

MMR (Measles, Mumps, Rubella)	**2 dose series** at ages 12-15 months and 4- 6 years of age. Minimum age to start the series is 12 months of age. Dose #2 maybe given before age 4, if at least 4 weeks since dose #1. MMR recommended for infants ages 6 through 11 months who are travelling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years.
MCV4 (Meningococcal)	One time dose of MCV4 given to adolescents ages 11 to 12 years or 13 to 18 years if not vaccinated and a booster dose at 16 years. Ages 6 weeks – 23 months- High risk- Infant series of Hib-MenCY at 2mo, 4 mo, 6 mo, and 12-15 mo or 2 dose series of MCV4-D (Menactra) at age 9 months and 12 months or at least 8 weeks apart. 2 dose series of MCV4 at least 8 weeks apart to high risk children aged 2 to 10 years (children with persistent complement component deficiency, anatomic or functional asplenia, and other high risk conditions).
PCV (Pneumococcal)	**4 dose series** of PCV13 at ages 2 mo, 4 mo, 6 mo, and 12-15 mo. PCV13 for all ages 2 – 59 months and children with medical conditions PPSV23 for children ages 2 years and older with medical conditions- 1 dose at least 8 weeks after the last dose of PCV. For children who completed the 4-dose series with PCV7, 1 supplemental dose of PCV13 should be given.
RV	**3 dose series** (Rotateq®) at ages 2 mo, 4 mo, 6 mo **or**

Molina's Preventive Health Guidelines are adopted from the American Academy of Pediatrics, CDC's Advisory Committee of Immunization Practices, the U.S. Preventive Services Task Force and the American Academy of Family Physicians. Molina recommends that clinical judgments be applied and that the treatments provided to members deviate from the guidelines when individual patient considerations and specific clinical situations dictate. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication; however they should be used with the clear understanding that continued research may result in new knowledge and recommendations. We recommend that the medical records contain appropriate documentation for clinical decisions. This Preventive Health Guideline is also available on the Molina website at: **www.molinahealthcare.com**.

Child (birth – 17 years)

Preventive Health Guidelines

Immunizations/ Vaccines	Guidelines
(Rotavirus)	**2 dose series** (Rotarix®) at ages 2 mo, and 4 mo. Minimum age to start the series is 6 weeks. **Do not** start the series for infants older than 14 weeks and 6 days. The final dose of the series administered by age 32 weeks (8 months 0 days).

Varicella (Chickenpox)	**2 dose series** at ages 12-15 months and 4-6 years. Dose #2 may be given earlier if at least 3 months have passed since dose #1. For children ages 12 months – 12 years, 2 dose series should be given at least 3 months apart. For children 13 years of age and older, 2 dose series with at least 4 weeks apart between doses.

Screenings & Testing	Guidelines
Anemia/Hematocrit/ Hemoglobin	Iron deficiency testing for children aged 12 months.
Lead Screening	At 12 and 24 months of age.
Tuberculosis (TB) Screening	For high-risk children and adolescents.
Chlamydia Screening	For all sexually active females 16 years of age and older. Use nucleic acid amplification technology urine tests for screening.
STI Screening	Screen sexually transmitted infections (chlamydia, gonorrhea, HIV, syphilis) and provide counseling for all sexually active adolescents.

Molina's Preventive Health Guidelines are adopted from the American Academy of Pediatrics, CDC's Advisory Committee of Immunization Practices, the U.S. Preventive Services Task Force and the American Academy of Family Physicians. Molina recommends that clinical judgments be applied and that the treatments provided to members deviate from the guidelines when individual patient considerations and specific clinical situations dictate. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication; however they should be used with the clear understanding that continued research may result in new knowledge and recommendations. We recommend that the medical records contain appropriate documentation for clinical decisions. This Preventive Health Guideline is also available on the Molina website at: **www.molinahealthcare.com**.

Adult (18 years and older)

Preventive Health Guidelines

Screenings & Testing	Guidelines
Blood Pressure/Hypertension	At least every 1 to 2 years or more frequent for those with higher blood pressure.
Breast Cancer Screening (Mammography)	Every 1 to 2 years for women 40 years of age and older.
Cervical Cancer Screening (Pap smears)	At least every 3 years for females who have a cervix.

Chlamydia Screening	For all sexually active females 24 years of age and younger and other asymptomatic females at increased risk. Use nucleic acid amplification technology urine tests for screening.
Cholesterol/ Lipid Disorder Screening	Every 5 years for men 35 years of age and older. Every 5 years for women 45 years of age and older if they are at increased risk for coronary heart disease. More frequent screening intervals for men 20 to 35 and women 20 to 45 years of age, if they are at increased risk for coronary heart disease or high lipid level.
Colorectal Cancer Screening	Begin screening for colorectal cancer at age 50 years, using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults. ▪ Fecal occult blood testing (FOBT) every year. ▪ Sigmoidoscopy every 5 years combined with high-sensitivity fecal occult blood testing every 3 years. ▪ Colonoscopy every 10 years.
Diabetes Screening	Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg. Recommended 3-year screening interval may vary based on clinician's discretion.
Gonorrhea Screening	For all sexually active adults at increased risk for infection.
HIV Testing	For all adults at increased risk for infection.
Obesity/Height/Weight/BMI	Periodically screen for obesity and offer intensive counseling and behavioral interventions to promote sustained weigh loss for obese adults.
Osteoporosis Screening	For women at increased risk, start at age 60.
Syphilis Screening	Adults at increased risk for infection.
Tuberculosis (TB) Screening	For high risk adults.
Vision and Hearing	For high risk adults (elderly and diabetics).
IHEBA - Staying Healthy Assessment (SHA)	**Initial health assessments/education should include the following:** Alcohol misuse; Depression; Physical activity/Healthy diet/Obesity; Tobacco use; Secondhand smoke; STI Violence, Family and partner. Please visit the Molina website to obtain assessment forms and educational tip

Screenings & Testing	Guidelines
	sheets: **www.molinahealthcare.com**

Immunizations/ Vaccines	Guideline

Tdap (Tetanus, diphtheria, pertussis)	One time dose of Tdap given to adults 64 years and younger who have not previously received Tdap dose, then followed by 1 dose of Td booster every 10
Hepatitis A	2 dose series for adults at increased risk. Second dose given 6 to 18 months after the first dose.
Hepatitis B	3 dose series for adults at increased risk, including diabetics under age 60.
Human Papillomavirus (HPV)	3 dose series (either HPV4 or HPV2) to all adult females 26 years of age and younger who have not completed the HPV series. Second dose should be given 1-2 months after the first dose and third dose given 6 months after the first dose. 3 dose series (HPV4) recommended for adult males 26 years of age and younger with
Influenza	1 dose annually during flu season for all adults. For additional influenza vaccination information, visit CDC website: http://www.cdc.gov/vaccines/vpd-vac/flu/default.htm
MMR (Measles, Mumps, Rubella)	1 or 2 doses for adults who lack evidence of immunity and are at increased risk. If dose #2 is recommended, give it no sooner than 4 weeks after dose #1.
Meningococcal	2 doses at least 2 months apart for adults with increased risk. For adults 55 years and younger, MCV4 is preferred over MPSV4 For adults 56 years and older, MPSV4 is preferred. Revaccination with MCV4 every 5 years to adults at increased risk Use MPSV4 if there is a permanent contraindication/precaution to MCV4.
Pneumococcal	1 dose of PPSV23 for adults at increased risk. One time revaccination 5 years after first dose for adults aged 19-64 at increased risk.
Varicella (Chickenpox)	2 dose series for all adults without previous immunization or evidence of immunity. Second dose should be administered 4 to 8 weeks after the first dose.
Zoster (herpes zoster)	1 dose for adults 60 years of age and older, regardless of a prior episode of herpes zoster.

Pregnant Woman
Preventive Health Guidelines

Prenatal Visits: all pregnant females should receive timely prenatal visit in the first trimester and throughout pregnancy.

- **First Trimester** (0 to 13 weeks of pregnancy)
- **Second Trimester** (14 to 27 weeks of pregnancy)
- **Third Trimester** (28 to 40 weeks of pregnancy)

Postpartum Visits: within **21 to 56 days (3 to 8 weeks)** after delivery.

- Postpartum visit may be completed by a PCP or OB/GYN

Immunizations/ Vaccines	Guidelines
Td/Tdap (Tetanus, diphtheria, pertussis)	Administer 1 dose of Tdap during each pregnancy (preferred during 27-36 weeks gestation) regardless of number of years since prior Td or Tdap vaccination.
Hepatitis B	All pregnant females should be tested for HBsAg during first trimester. Pregnant women who are identified as being at risk for infection during pregnancy (e.g., having more than one sex partner during the previous 6 months, been evaluated or treated for an STD, recent or current injection drug use, or having had an HBsAg-positive sex partner) should be vaccinated.
Influenza (Flu)	Annually during flu season. Inactivated influenza vaccine (TIV) is recommended for pregnant women. For additional influenza vaccination information, visit CDC website: http://www.cdc.gov/vaccines/vpd-vac/flu/default.htm

Screenings & Testing	Guidelines
HIV Testing	For all pregnant women during first prenatal visit
Chlamydia, Gonorrhea, Syphilis Screenings	For all pregnant women during first prenatal visit.
Diabetes Screening	For pregnant women during 24 and 28 weeks of pregnancy.
Bacteriuria, Asymptomatic	Screen for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks of gestation or at the first prenatal visit.
Iron Deficiency Anemia	Routine screening for iron deficiency anemia in asymptomatic pregnant women.
Rh (D) Incompatibility	Rh(D) blood typing and antibody testing for all pregnant women during their first prenatal visit. Repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24-28 weeks of gestation.
Screening, Education and Counseling	Alcohol misuse and tobacco use screening and counseling during prenatal visits; Breastfeeding education during prenatal and postpartum visits

Molina's Preventive Health Guidelines are adopted from the American Academy of Pediatrics, CDC's Advisory Committee of Immunization Practices, the U.S. Preventive Services Task Force, the American Academy of Family Physicians and American College of Obstetricians and Gynecologists. Molina recommends that clinical judgments be applied and that the treatments provided to members deviate from the guidelines when individual patient considerations and specific clinical situations dictate. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication; however they should be used with the clear understanding that continued research may result in new knowledge and recommendations. We recommend that the medical records contain appropriate documentation for clinical decisions. This Preventive Health Guideline is also available on the Molina website at: www.molinahealthcare.com.

We need your help conducting these regular exams in order to meet the targeted state and federal standards. If you have questions or suggestions related to well child care, please call our Health Education line at (866) 472-9483.

Emergency Care Services

Emergent and urgent care services are covered by Molina Healthcare without an authorization. This includes non-contracted providers outside of Molina Healthcare's service area.

(24) Hour Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available (24) hours a day, seven (7) days a week, to assess symptoms and help make good health care decisions.

HEALTHLINE (24-Hour Nurse Advice Line)	
English Phone:	(888) 275-8750
Spanish Phone:	(866) 648-3537
TTY:	(866) 735-2929 (English) (866) 833-4703 (Spanish)

Molina Healthcare is committed to helping our members:

- Prudently use the services of your office
- Understand how to handle routine health problems at home
- Avoid making non-emergent visits to the emergency room (ER)

These registered nurses do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, 911 or the ER. By educating patients, it reduces costs and over utilization on the health care system.

Health Management and Education Programs

Molina Healthcare of Texas wants you to be aware of health management programs offered to assist with care management. We have programs that can help you manage your patient's condition. These include programs, such as:

- Asthma
- Diabetes
- Cardiovascular Disease
- Congestive Heart Failure
- COPD

A Care Manager/Health Manager is on hand to teach your Patients about their disease. He/she will manage the care with the member's assigned PCP and provide other resources. There are many ways a member is identified to enroll in these programs. One way is through medical or pharmacy claims. Another way is through Nurse Advice Line or doctor referral. Members can also ask Molina to enroll them. It is the member's choice to be in these programs. A member can choose to get out of the program at any time.

For more info about our programs, please call:

- Member Services Department at (888) 560-2025
- TTY Relay: 711
- Visit www.molinahealthcare.com

Health Management Programs

Molina Healthcare of Texas Health Management programs provide patient education information to Members and facilitate provider access to these chronic disease programs and services.

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Molina members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the member opts out. Each identified member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified members will receive regular educational newsletters. The program model provides an "opt-out" option for members who contact Molina Member Services and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These may include the following:

- Pharmacy claims data for all classifications of medications;
- Encounter data or paid claim with a relevant CPT-4 or ICD-9 code;
- Member Services welcome calls made by staff to new member households and incoming member calls have the potential to identify eligible program participants. Eligible members are referred to the program registry;
- Practitioner/provider referral;
- Nurse Advice referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through member newsletter, the Nurse Advice Line or other member communication.

Practitioner/Provider Participation

Contracted practitioners/providers are automatically notified whenever their patients are enrolled in a health management program. Practitioner/provider resources and services may include:

- Annual practitioner/provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Patient education resources;
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines; and
- Preventive Health Guidelines;

Additional information on health management programs is available from your local Molina QI Department **toll free at (877) 711-7455.**

Pregnancy Health Management Program

We care about the health of our pregnant members and their babies. Molina's pregnancy program will make sure member and baby get the needed care during the pregnancy. You can speak with trained Nurses and Care Managers. They can give your office/member the support needed and answer questions you may have. You will be mailed a workbook and other resources which are also available to the member. The member will also learn ways to stay healthy after child birth. Special care is given to those who have a high-risk pregnancy. It is the member's choice to be in the program. They can choose to be removed from the program at any time. Molina Healthcare is requesting your office to complete the Pregnancy Notification form (refer to appendix B for form) and return it to us as soon as pregnancy is confirmed.

Although pregnancy itself is not considered a disease state, a significant percentage of pregnant females on Medicaid are found to be at moderate to high-risk for a disease condition for the mother, the baby or both. The Motherhood Matters [SM] pregnancy management program strives to reduce hospitalizations and improve birth outcome through early identification, trimester specific assessment and interventions appropriate to the potential risks and needs identified. The Motherhood Matters [SM] program does not replace or interfere with the member's physician assessment and care. The program supports and assists physicians in the delivery of care to members.

Motherhood Matters [SM] Program Activities

Motherhood Matters [SM] Pregnancy Health management Program encompasses clinical case management, member outreach and member and provider communication and education. The Prenatal Case Management staff works closely with the provider community in identification, assessment, and implementation of appropriate intervention(s) for every member participating in the program. The program activities include early identification of pregnant members, early screening for potential risk factors, provision of telephonic and written trimester appropriate education to all pregnant members and families, referral of high-risk members to prenatal case management, and provision of assessment information to physicians.

- Prenatal Case Management – Members assessed to be high risk are contacted via telephone for further intervention and education. A care plan is developed and shared with the physician to ensure that all educational and care needs are met. Prenatal case management registered nurses, in conjunction with the treating physician, coordinate health care services, including facilitation of specialty care referrals, coordination of home health care and DME service and referral to support groups or community social services. The case management data base generates reminders for call backs for specific assessments, prenatal visits, postpartum visits and well-baby checkups.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Health Management Unit.

- Member Outreach – Motherhood Matters [SM] Program is promoted to members through various means including, program brochures in new member Welcome Packets, other member mailings, member newsletters, provider newsletters, posters and brochures placed in practitioner's offices and marketing materials and collaboration with national and local community-based entities.

Weight Management

Weight Management Program Includes:

Given the diversity of Molina Healthcare's membership, a health management program created around weight management is designed to improve the quality of life among our members and enhance clinical outcomes in the future. Helping our members reduce unhealthy behaviors will improve their ability to manage pre-existing illnesses or chronic conditions.

Molina's Weight Management program is comprised of telephonic outreach by a multi-disciplinary team of Health Managers, Health Educators, and providers to support the weight management needs of the member.

Molina's Health education program encompasses one-on-one telephonic education and coaching. The Health Education staff work closely with the member's provider to implement appropriate intervention(s) for members participating in the program. The program consists of multi-departmental coordination of services for participating members and uses various approved health education/information resources such as: Centers For Disease Control, National Institute of Health, and Clinical Care Advance system for health information and assessment tools. Health education resources are intended to provide both general telephonic health education and targeted information based on the needs of the individual.

Goals of Weight Management Program:

The goals of the Weight Management program are to:

1. Counsel on the health benefits of weight loss.
    - One-on-one telephonic counseling
    - BMI Identification
    - Provider and community resource referral
2. Promote Healthy Eating Habits
    - Teach basic nutrition concepts
        - Healthy Plate Method
        - Meal spacing and portion control
        - Tips on grocery shopping
        - Label reading
        - Healthy cooking method tips
        - Eating out tips
3. Teach Behavior Modification techniques
    - Promote healthy lifestyle changes
    - Monitor eating behavior

- Rewarding oneself for healthy changes and progress

4. Encourage Regular Exercise
   - Advise member to always talk to their provider before starting any exercise program
   - Promote increased physical activity that is realistic and achievable.
     - Walking
     - Dancing
     - Sit and Be Fit program on PBS
   - Actively involve practitioners, members, families, and other care providers in the planning, implementation, and evaluation of care.
   - Monitor program effectiveness through the evaluation of outcomes.

Program Benefits:

1. Access to a Health Educator for telephonic counseling on weight management
2. Community class referrals in participating areas and self-help education materials if available
3. Referral to Online Programs; www.sparkpeople.com, www.sparkteens.com, www.choosemyplate.gov

To find out more information about the health management programs, please call Member Services Department at 1(888) 560-2025.

Smoking Cessation

Given the diversity of Molina Healthcare's membership, a health management program created around smoking cessation should improve the quality of life among our members and clinical outcomes in the future. Helping our members reduce unhealthy behaviors (i.e., quit tobacco use) will improve their ability to manage pre-existing illnesses or chronic conditions.

Molina's smoking cessation program uses a combination of telephonic outreach by a multi-disciplinary team of Care Managers, provider, and pharmacy engagement to support the smoking cessation needs of the member. The team works closely with contracted providers and pharmacist to identify appropriate pharmacologic cessation aids when applicable.

The goals of the Smoking Cessation program:

- Deal with the three aspects of smoking - Addiction, Habit, and Psychological Dependency
  - Use smoking cessation aids
  - Learning to Cope
  - Change beliefs
- Identify Stress Management & Coping Techniques
  - Practice relaxation & visualization techniques
  - Create support network
- Identify Pharmacologic Cessation Aids
- Prepare for Quit Day/Maintaining the Quit
  - Devise relapse prevention strategies
  - Review the Anticipate-Plan-Rehearse model
- Actively involve practitioners, members, families, and other care providers in the planning, provision, and evaluation of care.

- Improve the quality of information collection and statistical analysis; in order to assess the effectiveness of the program and to project future needs.
- Monitor program effectiveness through the evaluation of outcomes.

To find out more information about the health management programs, please call Member Services Department at 1(888) 560-2025 .

Section 5. Transportation

Non-Emergency Transportation

Molina Healthcare provides coverage for non-emergency transportation for Molina Marketplace Silver plan members who meet certain requirements. **To find out if this is a covered service for your patient, please contact Molina Healthcare at 855-322-4080.**

Non-Emergency Medical Transportation

For Molina Marketplace members who have non-emergency medical transportation as a covered service, Molina Healthcare covers transportation to medical facilities when the member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, air, etc.). This requires a written prescription from the member's doctor. Examples of non-Emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. Members must have Prior Authorization from Molina Healthcare for these services before the services are given. Additional information regarding the availability of this benefit is available by contacting Customer Service at **855-322-4080**.

Non-Emergency Non-Medical Transportation

Non-Emergency non-medical transportation is available to members who have non-emergency transportation as a covered service and are recovering from serious injury or medical procedure that prevents them from driving to a medical appointment. The member must have no other form of transportation available. Prior Authorization is required to access these services. A Physician (PCP or Specialist) confirmation that member require non-Emergency non-medical transportation to and from an appointment on a specified date. Additional information regarding the availability of this benefit is available by contacting Customer Services at **855-322-4080**.

Non-Emergency non-medical transportation for Members to medical services can be supplied by a passenger car, taxi cabs, or other forms of public/private transportation. Members are instructed to call the transportation vendor at least two to three working days before the appointment to arrange this transportation.

Emergency Transportation

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

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Section 6. Provider Responsibilities

This section describes Molina Healthcare's established standards on access to care, newborn notification process, and member marketing information for participating providers. In applying the standards listed below, participating providers have agreed they will not discriminate against any member on the basis of:

- Age
- Race
- Creed
- Color
- Religion
- Sex
- National origin
- Ancestry
- Sexual orientation
- Marital status
- Physical disability
- Mental or sensory handicap
- Place of residence
- Socioeconomic status
- Status as a recipient of Medicaid benefits

Additionally, participating providers or contracted medical groups/IPAs may not limit their practices because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If PCPs choose to close their panel to new members, Molina Healthcare must receive thirty (30) days advance notice from the provider.

Access to Care Standards

Molina Healthcare is committed to providing timely access to care for all members in a safe and healthy environment. Molina Healthcare will ensure providers offer hours of operation no less than offered to commercial members. Access standards have been developed to ensure that all health care services are provided in a timely manner. The PCP or designee must be available (24) hours a day, seven days a week to members for emergency services. This access may be by telephone. Appointment and waiting time standards are shown below. Any member assigned to a PCP is considered his or her patient.

For additional information about how Molina Healthcare audits access to care, please refer to Section 8 (Quality Improvement) of this manual.

Appointment Type For PCPs	When You should get the appointment
Urgent care appointments for Covered Services requiring Prior Authorization	Within 24 hours of the appointment request
Urgent care appointments for Covered Services not requiring Prior Authorization	Within 24 hours of the appointment request
Routine or non-urgent care appointments	Within 3 weeks of the appointment request for medical care; within two weeks of the appointment request for behavioral health care
Non-urgent care with a non-physician behavioral health care provider appointments	Within two weeks of the appointment request
Appointment Type For Specialist Physicians	When You should get the appointment
Urgent care appointments for Covered Services requiring Prior Authorization	Within 24 hours of the appointment request
Urgent care appointments for Covered Services not requiring Prior Authorization	Within 24 hours of the appointment request
Routine or non-urgent care appointments	Within 3 weeks of the appointment request for medical care; within two weeks of the appointment request for behavioral health care

Newborn Notification Process

Physicians must notify Molina Healthcare immediately of the first prenatal visit and/or positive pregnancy test of any member presenting themselves for healthcare services.

The PCP shall submit to Molina Healthcare the Pregnancy Notification Report Form (included in Appendix B) within 1 working day of the first prenatal visit and/or positive pregnancy test of any member presenting themselves for healthcare services. Providers shall enter all applicable information in sections (3) and (2) of the form. The form should be faxed to Molina Healthcare Member Services at 1-888-560-2025.

Relocations and Additional Sites

Providers should notify Molina Healthcare sixty (60) days in advance when they relocate or open an additional office. When this notification is received, a site review of the new office may be conducted before the provider's recredentialing date.

Site and Medical Record-Keeping Practice Reviews

As a part of Molina Healthcare's Quality Improvement Program, providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices. For details regarding these requirements and other QI program expectations please refer to Section 8 of this manual.

Member Information and Marketing

Any written informational and marketing materials directed at Molina Healthcare members must be written at or below the fifth (5^{th}) grade reading level, and have prior written consent from Molina Healthcare and the appropriate government agencies. Please contact your Provider Services Representative for information and review of proposed materials. Neither Molina Healthcare, nor any contracted providers nor medical groups/IPA may:

- Distribute to its members informational or marketing materials that contain false or misleading information
- Distribute to its members marketing materials selectively within the Service Area
- Directly or indirectly conduct door-to-door, telephonic, or other cold-call marketing for member enrollment

Section 7. Medical Management Program

Introduction

Molina Healthcare maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina Healthcare medical management program also ensures that Molina Healthcare only reimburses for services identified as a covered benefit and medically necessary . Elements of the Molina Healthcare medical management program include medical necessity review, prior authorization, inpatient management and restrictions on the use of non-network providers.

Medical Necessity Review

In conjunction with regulatory guidance from federal and state regulations and industry standards, Molina Healthcare only reimburses services provided to its members that are medically necessary. Molina Healthcare may conduct a medical necessity review of all requests for authorization and claims, within the specified time frame governed by Federal or State law for all lines of business. This review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively, as long as the review complies with Federal or State regulations and the Molina Healthcare Hospital or Provider Services Agreement.

Clinical Information

Molina Healthcare requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina Healthcare does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless state or federal regulations or the Molina Healthcare Hospital or Provider Services Agreement require such documentation to be acceptable.

Prior Authorization

Molina Healthcare requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Healthcare Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative

form, along with a more detailed list by CPT and HCPCS codes. Molina Healthcare prior authorization documents are updated annually and the current documents are posted on the Molina Healthcare website. Molina Healthcare has included at the end of this section of this manual a copy of the current Authorization Request form. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina Healthcare ID number, etc.)
- Provider demographic information (referring provider and referred to provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS and ICD-9 codes
- Clinical information sufficient to document the medical necessity of the requested service

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State law) are excluded from the prior authorization requirements. Molina Healthcare does not "retroactively" authorize services that require prior authorization.

Timeframes for service request are designated as follows:

TYPE OF REQUEST	TIME FRAME
Non-urgent pre-service decisions	Within three working days from the date the request is received in writing to the provider of record and the patient or the patient's representative unless the request is received outside of the period requiring the availability of UM personnel, the determination must be issued and transmitted within three working days from the beginning of the next time period requiring UM personnel. For determinations concerning an acquired brain injury, in addition to the information outlined above, notification of the determination through a direct telephone contact to the individual making the request is also required.
Urgent pre-service	Within three working days from the date the request is received in writing, unless the request is received outside of the period requiring the availability of UM personnel, the determination must be issued and transmitted within three calendar days from the beginning of the next time period requiring UM personnel. Notice is provided to the provider of record and the patient or the patient's representative. *See below for Inpatient and Post-stabilization.
Post-stabilization care	Within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, MHT shall

	provide the notice to the treating physician or other health care provider not later than one hour after the time of the request, unless the request is received outside of the period requiring the availability of appropriate personnel, the determination must be issued and transmitted within one hour from the beginning of the next time period requiring appropriate personnel. Followed by a letter within three working days notifying the patient, the patient's representative and the provider of record.
Urgent concurrent review (i.e. inpatient, ongoing ambulatory services)	Within 24 hrs. of receipt to provider/requestor by phone or electronic transmission to provider, unless the request is received outside of the period requiring the availability of appropriate personnel, then within 24 hours of the beginning of the next business day by phone or electronic transmission to provider. Followed by a letter within three working days notifying the patient, or person acting on behalf of the patient and the provider of record of the adverse determination.
Post-service decisions/Retrospective Reviews	30 calendar days (with extensions as outlined) for par providers notification timelines should be reviewed prior to processing post service decisions unless EMTALA applies)**-**
Standard Appeals	Within 30 calendar days of receipt, with notification provided to member, or member's representative and provider of record.
Expedited Appeals	Expedited appeal decisions must be completed based on the immediacy of the medical or dental condition, procedure, or treatment, but may in no event exceed one working day from the date all information necessary to complete the appeal is received; and the expedited appeal determination may be provided by telephone or electronic transmission, but must be followed with a letter within three working days of the initial telephonic or electronic notification to m to member, or member's representative and provider of record.

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider at () -1-855-322-4080.

Requesting Prior Authorization

Web Portal: Providers are encouraged to use the Molina Healthcare WebPortal for prior authorization submission. Instructions for how to submit a Prior Authorization Request are available on the Portal.

Fax: The Prior Authorization form can be faxed to Molina Healthcare at: 1-866-420-3639. If the request is not on the form provided in this manual, be sure to send to the attention of the Healthcare Services Department.

Phone: Prior Authorizations can be initiated by contacting Molina's Healthcare Services Department at 1-855-322-4080. It may be necessary to submit additional documentation before the authorization can be processed.

Mail: Prior Authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:

Molina Healthcare of Texas
Attn: Healthcare Services Dept.
5605 MacArthur Blvd. Suite 400
Irving, TX 75038Address

Inpatient Management

Elective Inpatient Admissions- Molina Healthcare requires prior authorization for all elective inpatient admissions to any facility. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions-Molina Healthcare requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. Molina Healthcare requires that notification includes member demographic information, facility information, date of admission and clinical information (see definition above) sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification and medical necessity requirements may result in a denial of authorization for the inpatient admission.

Concurrent Inpatient Review- Molina Healthcare performs concurrent inpatient review in order to ensure patient safety, medical necessity of ongoing inpatient services, and adequate progress of treatment and development of appropriate discharge plans. Performing these

functions requires timely clinical information updates from inpatient facilities. Molina Healthcare will request updated original clinical records from inpatient facilities at regular intervals during a member's inpatient admission. At the time of notification and for subsequent concurrent reviews requests for continued hospitalization, Molina Healthcare requires clinical information be submitted to process the request. Molina Healthcare will make a determination based on medical necessity within 24 business hours from notification. Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission.

Inpatient Status Determinations- Molina Healthcare supports appropriate utilization of observation status and routinely reviews all admissions to determine the medical necessity of the admission and if appropriate, may only approve of observation status if the member's stay in an inpatient facility was 2 days or less AND meets observation level medical necessity criteria. Inpatient stays greater than two (2) days will be reviewed as inpatient level of care confinements. Rare exceptions include when the admitting physician has clearly documented the reasons for an expectation of an inpatient stay lasting less than two (2) days and the patient expires, is transferred, or leaves the facility against medical advice (AMA) before the two (2) day stay is completed. Molina Healthcare applies this inpatient status determination methodology to all lines of business as long as the methodology complies with Federal or State regulations and the Molina Healthcare Hospital or Provider Services Agreement.

Note: This policy is effective 4/1/2014

Readmission Policy- Hospital readmissions within thirty (30) days potentially constitute a quality of care problem. Readmission review is an important part of Molina Healthcare's Quality Improvement Program to ensure that Molina Healthcare members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.

Molina Healthcare will review all hospital subsequent admissions that occur within the time frames allowed by federal and state law of the previous discharge for all claims. Reimbursement for readmissions will be combined with the prior admission unless it meets one of the exceptions noted below, violates State and/or Federal law or violates the terms of the Hospital or Provider Services Agreement between the Hospital and Molina.

Exceptions:

1. The readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature discharge or inadequate discharge planning in the first admission necessitated the second admission

2. The readmission is part of a medically necessary, prior authorized or staged treatment plan

3. There is clear medical record documentation that the patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning.

Definitions:
Readmission: A subsequent admission to an acute care hospital within a specified time frame of a prior admission for a related condition or as readmission is defined by State laws or regulations.

Related Condition: A condition that has a same or similar diagnosis or is a preventable complication of a condition that required treatment in the original hospital admission.

Note: This policy is effective 4/1/2014

Non-Network Providers- Molina Healthcare maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Healthcare members. Molina Healthcare requires members to receive medical care within the participating, contracted network of providers unless it is for emergency services as defined by federal law. If there is a need to go to a non-contracted provider, all care provided by non-contracted, non-network providers must be prior authorized by Molina Healthcare. Non-network providers may provide emergency services and stabilization care, without prior authorization or as otherwise required by Federal or State laws or regulations.

Emergency services for this section is defined as A) medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Avoiding Conflict of Interest

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

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

Coordination of Care

Molina Healthcare's Integrated Care Management, which includes Utilization Management, Case Management and Disease Management, will work with providers to assist with

coordinating services and benefits for members with complex needs and issues. It is the responsibility of contracted providers to assess members and with the participation of the member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change.

Molina Healthcare staff assist providers by identifying needs and issues that may not be verbalized by providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina Healthcare staff is done in partnership with providers and members to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members

It is Molina Healthcare's policy to provide members with advance notice when a provider they are seeing will no longer be in network. Members and providers are encouraged to use this time to transition care to an in-network provider. The provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the provider(s) assuming care. Under certain circumstances, members may be able to continue treatment with the out of network provider for a given period of time. For additional information regarding continuity of care and transition of members, please contact Molina Healthcare at 855-322 - 4080

If you are undergoing treatment for one of the conditions listed below and your doctor is no longer a Participating Provider with Molina Healthcare, Your doctor may contact Molina Healthcare to request that you stay with the doctor you are now seeing for continuity of care due to special circumstances. Your doctor must also agree not to charge you for any amount that you would not have been responsible for paying if the provider had remained in the Molina Healthcare network.

The following conditions may be eligible for special circumstances continuation of care:

- You have a serious chronic condition or disability. "**Serious Chronic Condition**" means a medical condition due to a disease, illness, or other medical problem or disorder that is serious in nature, and that does either of the following:
    - Persists without full cure or worsens over an extended period of time.
    - Requires ongoing treatment to maintain remission or prevent getting worse.
- If you have a Serious Chronic Condition or disability, you may be able to stay with the doctor for up to 90 days following termination of the provider agreement.
- You are past the 24th week of pregnancy. Continuation of coverage may extend through the delivery of your child and applies to immediate postpartum care and a follow-up check-up within the six-week period after delivery.

- You have a terminal illness. You may stay with the doctor or hospital for up to 9 months following termination of the provider agreement.

Eligibility for continuity of care is not based strictly upon the name of your condition.

Please note that the right to temporary continuity of care, as described above, does not apply to a newly enrolled Member undergoing treatment from a doctor or hospital that is not a Participating Provider with Molina Healthcare.

Continuity and Coordination of Provider Communication

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

Case Management

Molina Healthcare provides a comprehensive Case Management (CM) program to all members who meet the criteria for services. The CM program focuses on procuring and coordinating the care, services, and resources needed by members with complex issues through a continuum of care. Molina Healthcare adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina Healthcare case managers are licensed professionals and are educated, trained and experienced in the case management process. The CM program is based on a member advocacy philosophy, designed and administered to assure the member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

The CM program is individualized to accommodate a member's needs with collaboration and approval from the member's PCP. The Molina Healthcare case manager will arrange individual services for members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Healthcare case manager is responsible for assessing the member's appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Case Management: Members with high-risk medical conditions may be referred by their PCP or specialty care provider to the CM program. The case manager works collaboratively with all members of the health care team, including the PCP, hospital UM staff, discharge planners, specialist providers, ancillary providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the member being referred.

Members with the following conditions may qualify for case management and should be referred to the Molina Healthcare CM Program for evaluation:

- High-risk pregnancy, including members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease) cardiovascular disease, chronic pulmonary disease)
- Preterm births Infants requiring NICU care for more than 2 weeks
- High-technology home care anticipated to require more than two weeks of treatment
- Member accessing ER services inappropriately
- Members with frequent hospital admissions

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

Phone: (888) 560-2025

(888) 560-2025, extension 752042 Fax: 866.420.3639

PCP Responsibilities in Case Management Referrals

The member's PCP is the primary leader of the health team involved in the coordination and direction of services for the member. The case manager provides the PCP with reports, updates, and information regarding the member's progress through the case management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of members.

Case Manager Responsibilities

The case manager collaborates with all resources involved and the member to develop a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the case manager, providers, and the member are responsible for implementing the plan of care. Additionally the case manager:

Monitors and communicates the progress of the implemented plan of care to all involved resources

Serves as a coordinator and resource to team members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed

Coordinates appropriate education and encourages the member's role in self-help

Monitors progress toward the member's achievement of treatment plan goals in order to determine an appropriate time for the member's discharge from the CM program.

Health Education and Disease Management Programs

Molina Healthcare's Health Education and Disease Management programs will be incorporated into the member's treatment plan to address the member's health care needs. Primary prevention programs may include smoking cessation and wellness.

Emergency Services

Emergency services are covered on a (24) hour basis without the need for prior authorization for all members experiencing an emergency medical situation.

Molina Healthcare of Texas accomplishes this service by providing a (24) hour Nurse Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all members at the onset of any call to the plan.

For members within our service area: Molina Healthcare of Texas, Inc. contracts with vendors that provide (24) hour emergency services for ambulance and hospitals.

Medical Record Standards

The provider is responsible for maintaining an electronic or paper medical record for each individual member. Records are expected to be current, legible, detailed and organized to allow for effective and confidential patient care by all providers.

Medical records are to be stored in a secure manner that permits easy retrieval. Only authorized personnel may have access to patient medical records.

Providers will develop and implement confidentiality procedures to guard member protected health information, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and all other applicable federal and state regulations. The provider must ensure his/her staff receives periodic training regarding the confidentiality of member information.

The provider is responsible for documenting directly provided services. Such services must include, but not necessarily be limited to, family planning services, preventive services, services for the treatment of sexually transmitted diseases, ancillary services, diagnostic services and diagnostic and therapeutic services for which the member was referred to the provider.

At a minimum, each medical record must be legible and maintained in detail with the documentation outlined in section 8 (Quality Improvement) of this manual.

Medical Necessity Standards

"**Medically Necessary"** or "**Medical Necessity**" means health care services that a physician or other qualified healthcare provider exercising prudent clinical judgment, would provide to a patient for the

purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
1) In accordance with generally accepted standards of medical practice;
2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3) Not primarily for the convenience of the patient, physician, or other health care provider, and not more Costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Specialty Pharmaceuticals/Injectables and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases they will be made available through Molina Healthcare's vendor, Caremark Specialty Pharmacy. More information about our Prior Authorization process, including a PA request form, is available in Section 7 of this manual.

Molina's pharmacy vendor will coordinate with Molina Healthcare and ship the prescription directly to your office or the member's home. All packages are individually marked for each member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations Representative with any further questions about the program.

Prior Authorization Guidelines and Request Form

Molina Healthcare of Texas

Marketplace

Prior Authorization/Pre-Service Review Guide

Effective: 01/01/2014

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare Marketplace Members.

Referrals to Network Specialists do not require Prior Authorization
Office visits to contracted (par) providers do not require Prior Authorization

Authorization required for services listed below.
Pre-Service Review is required for elective services.
Only covered services are eligible for reimbursement

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:** Inpatient, Partial hospitalization, Day Treatment, Intensive Outpatient Programs (IOP), Electroconvulsive Therapy (ECT).
  - Non Physician/Advanced Practice Registered Nurse (APRN) BH Outpatient Visits & Community Based Outpatient programming: After initial evaluation for outpatient and home settings
- **Chiropractic Services**
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting):** which are not usually covered benefits include but are not limited to tattoo removal, collagen injections, rhinoplasty, otoplasty, scar revision, keloid treatments, surgical repair of gynecomastia, pectus deformity, mammoplasty, abdominoplasty, venous injections, vein ligation, venous ablation, dermabrasion, botox injections, etc
- **Dental General Anesthesia:** ≥ 7 years old
- **Dialysis:** notification only
- **Durable Medical Equipment:**
  Refer to Molina's website for specific codes that require authorization.
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing except** for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns mandated by state regulations
- **Home Healthcare:** After 3 skilled nursing visits
- **Home Infusion**
- **Hospice & Palliative Care:** notification only.
- **Imaging:** CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms, Intimal Media Thickness Testing, Three Dimensional (3D) Imaging
- **Inpatient Admissions: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility, Hospice** (Hospice requires notification only)
- **Neuropsychological and Psychological Testing and Therapy**
- **Non-Par Providers/Facilities: Office visits, procedures, labs, diagnostic studies, inpatient stays except for:**
  - Emergency Department services
  - Professional fees associated with ER visit, approved Ambulatory Surgery Center (ASC) or inpatient stay
  - Women's Health, Family Planning and Obstetrical Services
  - Child and Adolescent Health Center Services
  - Local Health Department (LHD) services
  - Other services based on state requirements
- **Nutritional Supplements & Enteral Formulas**
- **Occupational Therapy:** After initial evaluation for outpatient and home settings
- **Office-Based Surgical Procedures do not require authorization except for Podiatry Surgical Procedures** (excluding routine foot care)
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's website for specific codes that are **EXCLUDED** from authorization requirements
- **Pain Management Procedures:** including sympathectomies, neurotomies, injections, infusions, blocks, pumps or implants, and acupuncture
- **Physical Therapy:** After initial evaluation for outpatient and home settings
- **Pregnancy and Delivery:** notification only
- **Prosthetics/Orthotics:**
  Refer to Molina's website for specific codes that require authorization. Includes but not limited to:
  - Orthopedic footwear/orthotics/foot inserts
  - Customized orthotics, prosthetics, braces
- **Rehabilitation Services:** Including Cardiac and Pulmonary
- **Sleep Studies**
- **Specialty Pharmacy drugs (oral and injectable) used to treat the following disease states, but not limited to: Anemia, Crohn's/Ulcerative Colitis, Cystic Fibrosis, Growth Hormone Deficiency, Hemophilia, Hepatitis C, Immune Deficiencies, Multiple Sclerosis, Oncology, Psoriasis, Pulmonary Hypertension, Rheumatoid Arthritis, and RSV prophylaxis** (Refer to Molina's website for specific codes that require authorization)
- **Speech Therapy:** After initial evaluation for outpatient and home settings
- **Transplant Evaluation and Services including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization)
- **Transportation:** non-emergent ambulance (ground and air)
- **Unlisted and Miscellaneous Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.
- **Wound Therapy including Wound Vacs and Hyperbaric Wound Therapy**

***STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with claim.**

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT Lab or X-ray report/results)
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone/fax or electronic notification. Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition.
- Providers can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (866) 449-6849 X206660

Important Molina Healthcare Marketplace Information	
Prior Authorizations: 8:00 a.m. – 5:00 p.m. Phone: (855) 322-4080 Fax: (866) 420-3639 **Radiology Authorizations:** Phone: (855) 714-2415 Fax: 877- 731- 7218 **OB/NICU Authorizations:** Phone: (855) 714-2415 Fax: 877- 731- 7218 **Pharmacy Authorizations:** Phone: (855) 322-4080 Fax: (888) 487-9251 **Behavioral Health Authorizations:** Phone: (855) 322-4080 Fax: (866) 617-4967 **Transplant Authorizations:** Phone: (855) 714-2415 Fax: (877) 731- 7218 **Member Customer Service Benefits/Eligibility:** Phone: (888) 560-2025 TTY/TDD: (800) 735-2989	**Provider Customer Service:** 8:00 a.m. – 5:00 p.m. Phone: (855) 322-4080 Fax: (281) 599-8916 **24 Hour Nurse Advice Line** English: 1 (888) 275-8750 [TTY: 1-866/735-2929] Spanish: 1 (866) 648-3537 [TTY: 1-866/833-4703]

Providers may utilize Molina Healthcare's ePortal at: www.molinahealthcare.com
Available features include:

- **Authorization submission and status**
- **Claims submission and status** (EDI only)
- **Download Frequently used forms**
- **Member Eligibility**
- **Provider Directory**
- **Nurse Advice Line Report**

Molina Healthcare Marketplace Prior Authorization Request Form

Phone Number: (855) 322-4080

Fax Number: (866) 420-3639

MEMBER INFORMATION			
Plan:	☐ **Molina Marketplace**		☐ **Other:**
Member Name:		**DOB:**	/ /
Member ID#:		**Phone:**	( ) -
Service Type:	☐Elective/Routine	☐Expedited/Urgent*	

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

	Referral/Service Type Requested	
Inpatient ☐Surgical procedures ☐ER Admits ☐SNF ☐Rehab ☐LTAC	**Outpatient** ☐Surgical Procedure ☐Rehab (PT, OT, & ST) ☐Diagnostic Procedure ☐Chiropractic ☐Wound Care ☐Infusion Therapy ☐Other:	☐ **Home Health** ☐ **DME** ☐ **In Office**

ICD-9 Code & Description:			
CPT/HCPC Code & Description:			
Number of visits requested:		Date(s) of Service:	

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION	
Requesting Provider Name:	
Facility Providing Service:	
Contact at Requesting Provider's office:	

Phone Number:	( )	Fax Number:	( )

For Molina Use Only:

Section 8. Quality Improvement

Quality Improvement

Molina Healthcare of Texas maintains a Quality Improvement (QI) Department to work with members and practitioners/providers in administering the Molina Quality Improvement Program. You can contact the Molina QI Department **toll free at 877-711-7455 or fax 866-472-4583**.

The address for mail requests is:

Molina Healthcare of Texas, Inc.
Quality Improvement Department
84 NE Loop 410 – Suite 200
San Antonio, TX 78216

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

Molina has established a Quality Improvement (QI) Program that complies with regulatory and accreditation guidelines. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service and health of our members.

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

- Have a quality improvement program in place;
- Comply with and participate in Molina Quality Improvement Program including reporting of Access and Availability and provision of medical records as part of the HEDIS® review process; and
- Allow access to Molina QI personnel for site and medical record review processes.

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the member's record. Molina conducts a medical record review of all Primary Care Practitioner (PCPs) that have a 50 or more member assignment that includes the following components:

- Medical record confidentiality and release of medical records including behavioral health care records;

- Medical record content and documentation standards, including preventive health care;
- Storage maintenance and disposal; and
- Process for archiving medical records and implementing improvement activities.

Practitioners/providers must demonstrate compliance with Molina Healthcare of Texas's medical record documentation guidelines. Medical records are assessed based on the following standards:

Content

- Patient name or ID is on all pages;
- Current biographical data is maintained in the medical record or database;
- All entries contain author identification;
- All entries are dated and are indelibly documented;
- Medication allergies and adverse reactions are prominently displayed. Absence of allergies is noted in easily recognizable location;
- Chronic conditions are listed or noted in easily recognizable location;
- Past medical history;
- There is appropriate notation concerning use of substances, and for patients, there is evidence of substance abuse query;
- The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints and provides a risk assessment of the members health status;
- Consistent charting of treatment care plan;
- Working diagnoses are consistent with findings;
- Treatment plans are consistent with diagnoses;
- Encounter notation includes follow up care, call, or return instructions;
- Preventive health measures (i.e., immunizations, mammograms, etc.) are noted;
- A system is in place to document telephone contacts;
- Lab and other studies are ordered as appropriate;
- Lab and other studies are initialed by ordering practitioner/provider upon review with lab results and other studies are filed in chart;
- If patient was referred for consult, therapy, or ancillary service, a report or notation of result is noted at subsequent visit, or filed in medical record; and
- If the practitioner/provider admitted a patient to the hospital in the past twelve (12) months, the discharge summary must be filed in the medical record;
- Advanced Directives are documented for those 18 years and older.
- A release document for each member authorizing Molina Healthcare to release medical information for facilitation of medical care.
- Developmental screenings as conducted through a standardized screening tool.
- Documentation of the age-appropriate screening that was provided in accordance with the periodicity schedule and all EPSDT related services.
- Documentation of a pregnant member's refusal to consent to testing for HIV infection and any recommended treatment.

Organization

- The medical record is legible to someone other than the writer;
- Each patient has an individual record;
- Chart pages are bound, clipped, or attached to the file; and
- Chart sections are easily recognized for retrieval of information.

Retrieval

- The medical record is available to practitioner/provider at each encounter;
- The medical record is available to Molina Healthcare for purposes of quality improvement;
- The medical record is available to Texas Health and Human Services Commission, the External Quality Review Organization and other applicable State of Texas and Federal health agencies, upon request;
- The medical record is available to the member upon their request;
- Medical record retention process is consistent with state and federal requirements; and
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

- Medical Records are protected from unauthorized access;
- Access to computerized confidential information is restricted; and
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.

Additional information on medical records is available from your local Molina Quality Improvement Department **toll free at 877-711-7455**. See also Section 16 (HIPAA/Security) for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Access to Care

Molina is committed to timely access to care for all members in a safe and healthy environment. Practitioners/providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 95% availability for emergency services and 80% or greater for all other services. The PCP or his/her designee must be available 24 hours a day, 7 days a week to members.

Appointment Access

All practitioners/providers who oversee the member's health care are responsible for providing the following appointments to Molina members in the timeframes noted:

Appointment Type For PCPs	When You should get the appointment
Urgent care appointments for Covered Services requiring Prior Authorization	Within 24 hours of the appointment request
Urgent care appointments for Covered Services not requiring Prior Authorization	Within 24 hours of the appointment request
Routine or non-urgent care appointments	Within 3 weeks of the appointment request for medical care; within two weeks of the appointment request for behavioral health care
Non-urgent care with a non-physician behavioral health care provider appointments	Within two weeks of the appointment request
Appointment Type For Specialist Physicians	When You should get the appointment
Urgent care appointments for Covered Services requiring Prior Authorization	Within 24 hours of the appointment request
Urgent care appointments for Covered Services not requiring Prior Authorization	Within 24 hours of the appointment request
Routine or non-urgent care appointments	Within 3 weeks of the appointment request for medical care; within two weeks of the appointment request for behavioral health care

Additional information on appointment access standards is available from your local Molina QI Department **toll free at 877-711-7455**.

After Hours

All practitioners must have back-up (on call) coverage after hours or during the practitioner's absence or unavailability. Molina requires practitioners to maintain a twenty-four (24) hour phone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. For primary care physicians, if the office telephone is answered after normal business hours by a recording, it should be in the language of each of the Major Population Groups served, directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone.

Appointment Scheduling

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

a. The practitioner must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
b. A process for documenting missed appointments must be established. When a member does not keep a scheduled appointment, it is to be noted in the Member's record and the practitioner is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the practitioner is to notify the **Molina Member Services Department toll free at 866-449-6849or TTY/TDD** 866-449-6849;
c. When the practitioner must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
d. Special needs of members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using members and members requiring language translation;
e. A process for member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and
f. A process must be established for member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating practitioners/providers have agreed that they will not discriminate against any member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, and place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating practitioner/provider or contracted medical group/IPA may not limit his/her practice because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care.

Women's Health Access

Molina allows members the option to seek obstetrical and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina Healthcare of Texas as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure members have direct access to participating providers for obstetrical and gynecological services.

Additional information on access to care is available under the Resources tab on the Molinahealthcare.com website or from your local Molina QI Department **toll free at 877-711-7455**.

Monitoring Access Standards

Molina monitors compliance with the established access standards above. At least annually, Molina conducts an access audit of randomly selected contracted practitioner/provider offices to determine if appointment access standards are met. One or all of the following appointment scenarios may be addressed: routine care; acute care; preventive care; and after-hours information. Results of the audit are distributed to the practitioners after its completion. A corrective action plan may be required if standards are not met.

In addition, Molina's Member Services Department reviews member inquiry logs and grievances related to delays in access to care. These are reported quarterly to committees. Delays in access that may create a potential quality issue are sent to the QI Department for review.

Additional information on access to care is available under the Resources tab at Molinahealthcare.com or is available from your local Molina QI Department **toll free at 877-711-7455**.

Site and Medical Record Keeping Practice Reviews

Molina Healthcare has a process to ensure that the offices of all practitioners meet its office-site and medical record keeping practices standards. Molina assesses the quality, safety and accessibility of office sites where care is delivered. A standard survey form is completed at the time of each visit. This form includes the Office Site Review Guidelines and the Medical Record Keeping Practice Guidelines outlined below and the thresholds for acceptable performance against the criteria. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Availability of appointments
- Adequacy of medical/treatment record keeping

Adequacy of medical record-keeping practices

During the site-visit, Molina discusses office documentation practices with the practitioner or practitioner's staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and includes how the practice ensures confidentiality of records. Molina assesses one medical/treatment record for orderliness of record and documentation practices. To ensure member confidentiality, Molina reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

OFFICE SITE REVIEW GUIDELINES AND COMPLIANCE STANDARDS

Practitioner office sites must demonstrate an overall 80% compliance with the Office Site Review Guidelines listed below. If a serious deficiency is noted during the review but the

office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

Facility
• Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
• Handicapped parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
• Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per physician.

Access
Standards for appointment scheduling include:
• Next available date for routine care is < = 21 calendar days
• Next available for adult sick visit (serious problem, not emergent) is within 24hours
• Next available for pediatric sick visit (serious problem, not emergent) is within 24 hours
• Standard wait time to be seen for a scheduled appointment is less than 1 hour.

Safety
• Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
• At least one CPR certified employee is available
• Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with 10 or more employees.
• A container for sharps is located in each room where injections are given.
• Labeled containers, policies, and contracts evidence hazardous waste management.

Administration & Confidentiality
• Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
• Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
• Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
• A CLIA waiver is displayed when the appropriate lab work is run in the office.
• Prescription pads are not kept in exam rooms.
• Narcotics are locked, preferably double locked. Medication and sample access is restricted.
• System in place to ensure expired sample medications are not dispensed and injectibles and emergency medication are checked monthly for outdates.
• Drug refrigerator temperatures are documented daily.

MEDICAL RECORD KEEPING PRACTICE GUIDELINES AND COMPLIANCE STANDARDS

Practitioner medical record keeping practices must demonstrate an overall 80% compliance with the Medical Record Keeping Practice Guidelines listed below. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

• Each patient has a separate medical record. File markers are legible. Records are stored away from patient areas and preferably locked. Record is available at each patient visit. Archived records are available within 24-hours.
• Pages are securely attached in the medical record. Computer users have individual passwords.
• Medical records are organized by dividers or color-coding when the thickness of the record dictates.
• A chronic problem list is included in the record for all adults and children.
• Allergies (and the lack of allergies) are prominently displayed at the front of the record.
• A complete health history questionnaire or H&P is part of the record.
• Health Maintenance forms includes dates of preventive services.
• A medication sheet is included for chronic medications.
• Advance Directives discussions are documented for those 18 years and older.
• Record keeping is monitored for Quality Improvement and HIPAA compliance.

Within 30 calendar days of the review, a copy of the site review report, the medical record keeping practices report and a letter will be sent to the medical group notifying them of their results.

Improvement Plans/Corrective Action Plans

If the medical group does not achieve the required compliance with the site review standards and/or the medical record keeping practices review standards, the Site Reviewer will do all of the following:
• Send a letter to the Practitioner that identifies the compliance issues.
• Send sample forms and other information to assist the Practitioner to achieve a passing score on the next review.
• Request the Practitioner to submit a written corrective action plan to Molina within 30 calendar days.
• Send notification that another review will be conducted of the office in six months.

When compliance is not achieved, the Practitioner will be required to submit a written corrective action plan (CAP) to Molina within 30 calendar days of notification by Molina Healthcare. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager or practitioner and must include the expected time frame for completion of activities.
Additional reviews are conducted at the office at six-month intervals until compliance is achieved. At each follow-up visit a full assessment is done to ensure the office meets performance standards. The information and any response made by the practitioner is included in the practitioners permanent credentials file and reported to the Credentialing Committee on the watch status report. If compliance is not attained at follow-up visits, an updated CAP will be required.

Practitioners who do not submit a CAP may be terminated from network participation. Any further action is conducted in accordance with the Molina Fair Hearing Plan policy.

Advance Directives (Patient Self-Determination Act)

Advance Directives

Practitioners/providers must inform adult Molina members (18 years old and up) of their right to make health care decisions and execute Advance Directives. It is important that members are informed about Advance Directives. During routine Medical Record review, Molina Healthcare auditors will look for documented evidence of discussion between the practitioner/provider and the member. Molina will notify the provider via fax of an individual member's Advance Directives identified through care management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are state specific to meet state regulations.

Each Molina practitioner/provider must honor Advance Directives to the fullest extent permitted under law. Members may select a new PCP if the assigned provider has an objection to the beneficiary's desired decision. Molina Healthcare will facilitate finding a new PCP or specialist as needed**.**

PCPs must discuss Advance Directives with a member and provide appropriate medical advice if the member desires guidance or assistance. Molina's network practitioners and facilities are expected to communicate any objections they may have to a member directive prior to service whenever possible. In no event may any practitioner/provider refuse to treat a member or otherwise discriminate against a member because the member has completed an Advance Directive. CMS law gives members the right to file a complaint with Molina Healthcare or the state survey and certification agency if the member is dissatisfied with Molina Healthcare's handling of Advance Directives and/or if a practitioner/provider fails to comply with Advance Directives instructions.

Advance Directives are a written choice for health care. There are three types of advance directives:

- Durable Power of Attorney for Health Care: allows an agent to be appointed to carry out health care decisions

- Living Will: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration

- Guardian Appointment: allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary

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

Services to Enrollees Under Twenty-One (21) Years

Molina Healthcare maintains systematic and robust monitoring mechanisms to ensure all Enrollees under twenty-one (21) Years are timely according to required preventive health guidelines. All Enrollees under twenty-one (21) years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the by the preventive health guidelines included in section 4 of this manual.

Well child / adolescent visits

Visits consist of age appropriate components including but not limited to:

- comprehensive health history;
- nutritional assessment;
- height and weight and growth charting;
- comprehensive unclothed physical examination;
- immunizations;
- laboratory procedures, including lead toxicity testing;
- periodic objective developmental screening using a recognized, standardized developmental screening tool
- objective vision and hearing screening;
- risk assessment;
- anticipatory guidance;
- periodic objective screening for social, emotional, development using a recognized, standardized tool,; and
- perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit.

Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

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

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Within (30) calendar days of the review, a copy of the review report and a letter will be sent to the medical group notifying them of their results. Performance below Molina Healthcare's standards may result in a corrective action plan (CAP) with a request the Provider submit a written corrective action plan to Molina Healthcare within (30) calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new members.

Quality Improvement Activities and Programs

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

Clinical Practice Guidelines

Molina Healthcare adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-practitioner/provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established Authority. Clinical Practice Guidelines are reviewed annually and are updated as new recommendations are published.

Molina Clinical Practice Guidelines include the following:

Asthma	Cholesterol
Chronic Obstructive Pulmonary Disease (COPD)	Coronary Heart Disease
Depression	Diabetes
Hypertension	Substance Abuse Treatment
ADHD	

The adopted Clinical Practice Guidelines are distributed to the appropriate practitioners, providers, provider groups, staff model facilities, delegates and members by the Quality Improvement, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina Healthcare Website. Individual practitioners or members may request copies from your local Molina Healthcare QI Department **toll free at 877-711-7455**.

Preventive Health Guidelines

Molina Healthcare provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Mammography screening;
- Prostate cancer screening;
- Cholesterol screening;
- Influenza, pneumococcal and hepatitis vaccines.
- Childhood and adolescent immunizations;
- Cervical cancer screening;
- Chlamydia screening;
- Prenatal visits.

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to practitioners/providers via www.molinahealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

Molina serves a diverse population of members with specific cultural needs and preferences. Practitioners/providers are responsible to ensure that interpreter services are made available at no cost for members with sensory impairment and/or who are Limited English Proficient (LEP). The following cultural and linguistic services are offered by Molina Healthcare to assist both members and practitioners/providers.

24 Hour Access to Interpreter

Practitioners/providers may request assistance in interpreting for members whose primary language is other than English by calling **Molina Healthcare toll free at** 866-449-6849**.** If Member Services Representatives are unable to provide the interpretation services internally, the member and practitioner/provider are immediately connected to a Language Line telephonic interpreter service.

If a patient insists on using a family member as an interpreter after being notified of his or her right to have a qualified interpreter at no cost, document this in the member's medical record. Molina is available to assist you in notifying members of their right to an interpreter. All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done via interpreter services. Practitioners/providers should document who provided the interpretation service. That information could be the name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreter's name, operator code number and vendor.

Additional information on cultural and linguistic services is available at www.molinahealthcare.com and from your local Provider Services Representatives and from the Molina Member Services Department.

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®);
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
- Provider Satisfaction Survey; and
- Effectiveness of Quality Improvement Initiatives.

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

Molina' Healthcare's most recent results can be obtained from your local Molina Healthcare QI Department **toll free at**

877-711-7455 or fax 866-472-4583.

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HEDIS®

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

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

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

CAHPS®

CAHPS® is the tool used by Molina to summarize member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Promotion and Education, Coordination of Care and Customer Service. The CAHPS® survey is administered annually in the spring to randomly selected members by a NCQA certified vendor.

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

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on member experience with health care practitioners/providers and health plans, Molina Healthcare conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods we use to identify improvement areas pertaining to the Molina Healthcare Provider Network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-provider

communications, and pharmacy authorizations. This survey is fielded to a random sample of practitioners/providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

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

Section 9. Claims

As a contracted provider, it is important to understand how the claims process works to avoid delays in processing your claims. The following items are covered in this section for your reference:

- Claim Submission
- Corrected Claim
- Claims Disputes/Adjustments
- Overpayments/Refund Requests
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Billing the member

Claim Submission

Claims may be submitted to Molina Healthcare with appropriate documentation by mail or filed electronically (EDI) for CMS-1500 and UB-04 claims. For members assigned to a delegated medical group/IPA that processes its own claims, please verify the "Remit To" address on the member's Molina Healthcare ID card (Refer to Section 2). Providers billing Molina Healthcare directly should send claims to:

Molina Healthcare of Texas , Inc.
PO Box 22719
Long Beach, CA 90801

Providers billing Molina Healthcare electronically should use current HIPAA compliant ANSI X12N format (e.g., 837I for institutional claims, 837P for professional claims, and 837D for dental claims) and use electronic payor ID number: 20554

Providers must use good faith effort to bill Molina Healthcare for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge. The following information must be included on every claim:

- Institutional Providers:
    - The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC. Entries stated as mandatory by NUBC and required by federal statue and regulations and any state designated data requirements included in statues or regulation.

- Physicians and Other Professional Providers:
    - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format. Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD) codes. Entries states as mandatory by NUCC and required by federal statute and regulation and any state designated data requirements included in statutes or regulations.

National Provider Identifier (NPI)

Providers must report any changes in their NPI or subparts to Molina Healthcare within thirty (30) calendar days of the change.

Documents that do not meet the criteria described above may result in the claim being denied or returned to the provider. Claims must be submitted on the proper claim form, either a CMS-1500 or UB-04. Molina Healthcare will only process legible claims received on the proper claim form containing the essential data requirements. Incomplete, inaccurate, or untimely re-submissions may result in denial of the claim.

Electronic Claim Submissions

Molina Healthcare also accepts electronic claim submissions for both claims and encounters using the CMS-1500 and UB-04 claim types. Please use Molina Healthcare's Electronic Payor ID number – 20554 It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When your claims are filed electronically:

- You should receive an acknowledgement from your current clearinghouse
- You should receive an acknowledgement from Emdeon within two (2) business days of your transmission
- You should contact your local clearinghouse representative if you experience any problems with your transmission
- For any direct submissions to Molina you should receive an acknowledgement of your transmission

Timely Claim Filing

Provider shall promptly submit to Molina Healthcare claims for Covered Services rendered to members. All claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures. Claims must be submitted by provider to Molina Healthcare within Ninety Five (95) calendar days after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and provider has been furnished with the correct name and address of the member's health maintenance organization. If Molina Healthcare is not the primary payer under coordination of benefits or third party liability, provider must submit claims to Molina Healthcare within insert state standard calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any claims that are not submitted to Molina Healthcare within these timelines shall not be eligible for payment and provider hereby waives any right to payment therefore.

Fraud and Abuse

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

Timely Claim Processing

Claims payment will be made to contracted providers in accordance with the timeliness provisions set forth in the provider's contract. Unless the provider and Molina Healthcare or contracted medical group/IPA have agreed in writing to an alternate payment schedule, Molina Healthcare will pay the provider of service within 30 days after receipt of clean claims.

The receipt date of a claim is the date Molina Healthcare receives either written or electronic notice of the claim.

Claim Editing Process

Molina Healthcare has a claims pre-payment auditing process that identifies frequent billing errors such as:

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

Coding edits are generally based on state fee for service Medicaid edits, AMA, Current Procedural Terminology (CPT), HRSA and National Correct Code Initiative (NCCI) guidelines. If you disagree with an edit please refer to the Claim Disputes/Adjustments section below.

Coordination of Benefits and Third Party Liability

For members enrolled in a Molina Marketplace plan, Molina Healthcare and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these members. Molina Marketplace will pay claims for covered services, however if TPL/COB is determined post payment, Molina Marketplace will attempt to recover any overpayments.

Corrected Claims

Corrected claims are considered new claims. Corrected claims may be submitted electronically with the appropriate field on the 837 I or 837 P completed. Paper corrected claims need to be marked as "**corrected**" and should be submitted to the following address:

Molina Healthcare of Texas , Inc.
PO Box 22719
Long Beach, CA 90801

Claims Disputes/Adjustments

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

Providers should submit the following documentation:

- The item(s) being resubmitted should be clearly marked as a Claim Dispute/ Adjustment.
- Payment adjustment requests must be fully explained.
- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the Referral/Authorization form (if applicable) must accompany the adjustment request.
- The claim number clearly marked on all supporting documents

These requests shall be classified as a Claims Disputes/Adjustment and be sent to the following address:

Molina Healthcare of Texas, Inc.
Attention: Claims Disputes / Adjustments

15115 Park Row Blvd. Suite # 110

Houston, Texas 77084

Requests for adjustments of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

The Provider will be notified of Molina Healthcare's decision in writing within insert state standard here days of receipt of the Claims Dispute/Adjustment request. Providers may request a claim dispute/adjustment when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina Healthcare determines that it has made an overpayment to a provider for services rendered to a member, it will make a claim for such overpayment. Molina Healthcare will not reduce payment to that provider for other services unless the provider agrees to the reduction or fails to respond to Molina Healthcare's claim as required in this subsection.

A provider shall pay a claim for an overpayment made by a Molina Healthcare which the provider does not contest or deny within the specified number of days on the refund request letter mailed to the provider.

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment.

Billing the Member

Molina Healthcare contracted providers may collect applicable Cost Sharing including co-payments, deductibles, and coinsurance from the member as required by the agreement. The contract between the provider and Molina Healthcare places the responsibility for verifying eligibility and obtaining approval for those services that require prior authorization on the provider

Encounter Data

Each capitated provider/organization delegated for Claims payment is required to submit encounter data to Molina Healthcare for all adjudicated Claims. The data is used for many purposes, such as reporting to HFS, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS reporting.

Encounter data must be submitted once per month, and must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina Healthcare should be reported.

Molina Healthcare shall have a comprehensive automated and integrated encounter data system capable of meeting these requirements.

Molina Healthcare will create Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to providers.

Section 10. Hospitals

This section includes policies and procedures specific to contracted hospitals. We have included information pertaining to Emergency Care and Admissions.

Emergency Care

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent emergency care services rendered to the member do not require prior authorization from Molina Healthcare.

Members accessing the emergency department inappropriately will be contacted by Molina Healthcare Case Managers whenever possible to determine the reason for using emergency services. Case Managers will also contact the PCP to ensure that members are not accessing the emergency department because of an inability to be seen by the PCP.

Admissions

Hospitals are required to notify Molina Healthcare within (24) hours or the first working day of any inpatient admissions, including deliveries, in order for hospital services to be covered. Prior authorization is required for inpatient or outpatient surgeries. Retroactive authorization requests for services rendered will normally not be approved.

Claims Submission

Claims must be submitted in accordance with the guidelines and processes set forth in the "Claims" section of this manual.

Section 11. Fraud, Waste and Abuse

Introduction

Molina Healthcare maintains a comprehensive Fraud, Waste and Abuse program. The program is held accountable for the special investigative process in accordance with federal and state statutes and regulations. The Program is administered by the Compliance department and is responsible for the prevention, detection, and investigation and reporting of potential health care fraud and abuse cases to the appropriate law enforcement and regulatory entities. The Program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare.

Mission Statement

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

Compliance Department Contact Information:

Molina maintains confidential reporting mechanisms that providers can use to report suspected fraud, waste, and abuse. The Molina Healthcare Alert Line is available 24/7 and can be reached at any time (day or night), over the weekend, or even on holidays. To report an issue by telephone, call toll-free at (866) 606-3889. To report an issue online, visit https://molinahealthcare.AlertLine.com. You may also directly mail the Compliance Official at:

Mail:

Director of Compliance

Molina Healthcare of Texas

5605 N. MacArthur Blvd

Suite 400

Irving, TX 75048

DEFINITIONS

Fraud:

Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. This includes any act that constitutes fraud under applicable Federal or State law.

Waste:

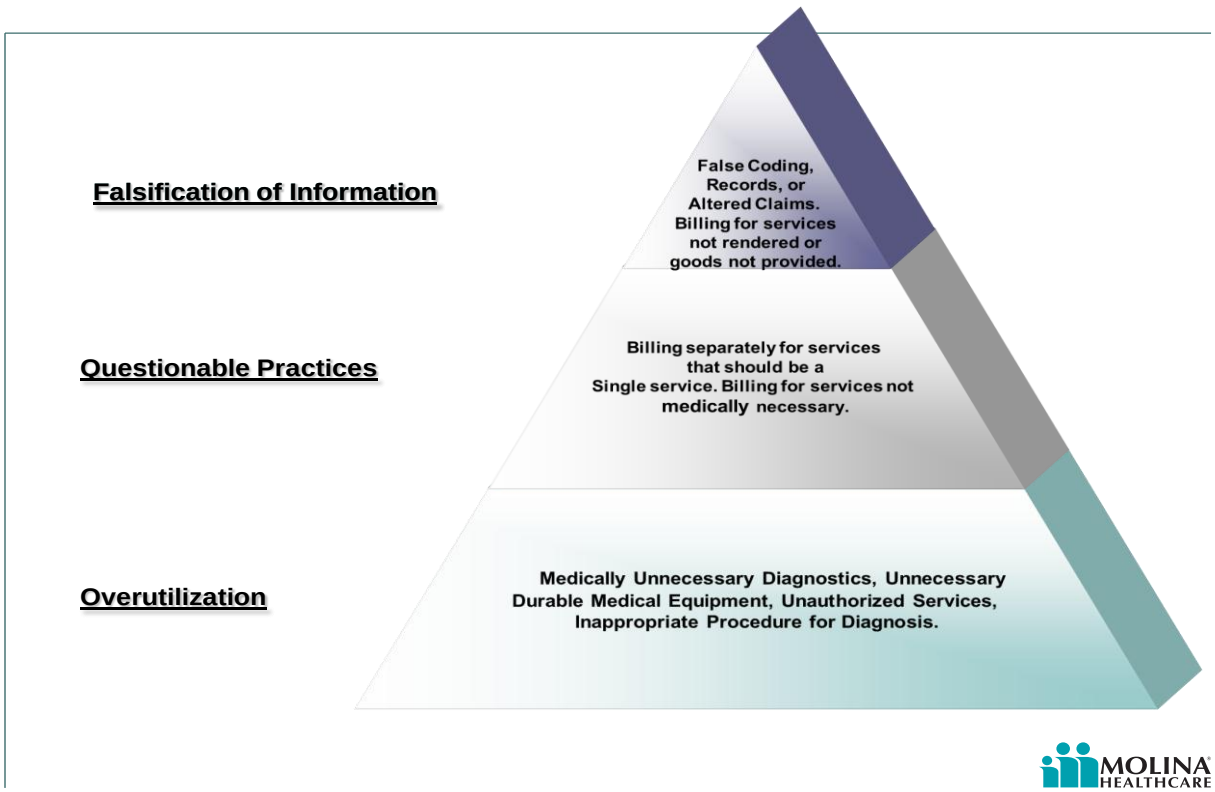
Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services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

Abuse:

Practices that is inconsistent with sound fiscal, business or medical practices that result in an unnecessary cost to the government program or in reimbursement for services that are not medically necessary, or fail to meet professionally recognized standards for health care.

Examples of Fraud, Waste and Abuse by a Provider

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



Review of Provider

The Credentialing Department is responsible for monitoring practitioners through the various government reports, including but not limited to:

- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Medicaid suspended and ineligible provider list.
- Monthly review of each state Medical Board “Hot Sheet.”
- Review of license reports from the appropriate specialty board.

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate government entity. Upon receiving this information the documents are presented to the Credentials Committee for review and potential action. The Credential Services staff will also present the list of physicians found on the Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

Provider Profiling

Molina Healthcare performs claims audits to detect potential external health care fraud. These audits of provider billings are based on objective and documented criteria. Molina Healthcare uses a fraud and abuse detection software application designed to score and profile providers and members billing behavior and patterns on a daily basis. The software utilizes a fraud finder engine to identify various billing behaviors, billing patterns, known schemes, as well as unknown patterns by taking into consideration a provider or member's prior billing history. The software statistically identifies what is expected based on prior history and specialty norms, including recognition of pattern changes from those identified in profiled historical paid claims data and ongoing daily claims batches. If a score reaches a certain parameter or threshold, the provider or member is placed on a list for further review.

A provider profile report is then created and sent to the Compliance Department. Molina Healthcare will inform the provider of the billing irregularities and request an explanation of the billing practices. The Compliance department may conduct further investigation and take action as needed.

Provider/Practitioner Education

When the Compliance Official identifies through an audit, provider profile or other means a situation with a provider (e.g. coding, billing) that is either inappropriate or deficient, the Compliance Officer may determine that a provider/practitioner education visit is appropriate.

The Compliance Official will contact the provider/practitioner's Provider Services Representative regarding the education issue. The Provider Services Representative will be informed that an on-site meeting at the provider's office is required in order to educate the provider on certain issues identified as inappropriate or deficient.

Review of Provider Claims and Claims System

Molina Healthcare Claim Examiners are trained to recognize unusual billing practices and to detect fraud and abuse. If the Claim Examiner suspects fraudulent billing practices, the billing practice is documented and reported to the Compliance Official of the state health plan in question.

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

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

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste or abuse, you must report it to Molina's **Compliance Official**. You have the right to have your concerns reported anonymously without fear of retaliation. Remember to include the following information when reporting suspected fraud or abuse:

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

You may also report suspected fraud and abuse related directly to the state at:

Texas Health and Human Services Commission
Office of Inspector General
P.O. Box 85200
Austin, Texas 78708-5200

Toll Free Phone: (**800) 436-6184**
Visit https://oig.hhsc.state.tx.us and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form

Office of the Attorney General

300 W. 15th Street

Austin, TX 78701

800-252-8011

Section 12. Credentialing and Recredentialing

The purpose of the Credentialing Program is to strive to assure that the Molina Healthcare network consists of quality practitioners/providers who meet clearly defined criteria and standards. It is the objective of Molina Healthcare to provide superior health care to the community.
The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer practitioners/providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.
The Credentialing Program has been developed in accordance with state and federal requirements and accreditation guidelines. In accordance with those standards, Molina Healthcare members will not be referred and/or assigned to you until the credentialing process has been completed.

Criteria for Participation in the Molina Healthcare Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the Molina network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network.

To remain eligible for participation practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina Healthcare.

Molina reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. Molina may, after considering the recommendations of the Credentialing Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined that such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any practitioner to a hearing or any other rights of review.

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

1. Practitioner must practice, or plan to practice within 90 calendar days, within the area served by Molina.
2. All providers, including ancillary providers, (i.e. vision, pharmacy, etc.), will apply for enrollment in the Medicaid program. Providers are required to have an NPI or an Administrative Provider Identification Number (APIN).
3. Practitioner must have a current, valid license to practice in their specialty in every state in which they will provide care for Molina members.
4. Practitioner must have current professional malpractice liability coverage with limits that meet Molina criteria specifically outlined in Addendum B of this policy.

5. If applicable to the specialty, practitioner must have a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration.
6. Dentists, Oral Surgeons, Physicians (MDs, DOs) and Podiatrists will only be credentialed in an area of practice in which they have adequate training as outlined below. Therefore, they must confine their practice to their credentialed area of practice when providing service to Molina Healthcare members. Adequate training must be demonstrated by one of the following:
7. Current Board Certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association in the credentialed area of practice, the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM), or the American Board of Oral and Maxillofacial Surgery
8. Successful completion of a training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians in Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must have completed a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).
9. Practitioners who are not Board Certified as described in section 5a above and have not completed an accredited Residency program are only eligible to be considered for participation as a General Practitioner in the Molina Healthcare network. To be eligible as a General Practitioner, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.
10. At the time of initial application, the practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body.[1]. This would include Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent
11. Practitioner must not be currently excluded, expelled or suspended from any state or federally funded program including, but not limited to, the Medicare or Medicaid programs.
12. Practitioner must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including, but not limited to, healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
13. Physician Assistants and Nurse Practitioners, who are not licensed to practice independently but are required to be credentialed, must have a practice plan with a supervising physician approved by the state licensing agency. The supervising physician must be contracted and credentialed with Molina.
14. Physicians (MD, DO), Primary Care Practitioners, Midwives, Oral Surgeons, Podiatrists and /or those practitioners dictated by state law, must have admitting privileges in their specialty or have a plan for hospital admission by using a Hospital Inpatient Team or having an arrangement with a credentialed Molina participating practitioner that has the ability to admit Molina Healthcare patients to a hospital. Practitioners practicing exclusively on a consultative basis are not required to have admitting hospital privileges. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical

[1] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

Medicine and Rehabilitation, Psychiatry, Sleep Medicine, Sports Medicine, Urgent Care and Wound Management do not require admitting privileges.

15. Licensed midwives who perform deliveries outside of an acute care hospital must have a formal arrangement in place with an OB/Gyn contracted and credentialed with Molina Healthcare. This arrangement must include 24-hour coverage and inpatient care for Molina members in the event of emergent situations. Family Practitioners providing obstetric care may provide the back-up in rural areas that do not have an OB/Gyn. This back-up physician must be located within 30 minutes from the midwives practice.
1. Nurse Midwives, Licensed Midwives, Oral Surgeons, Physicians, Primary Care Practitioners and Podiatrists must have a plan for shared call coverage that includes 24-hours a day, seven days per week and 365 days per year. The covering practitioner(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Sleep Medicine, Sports Medicine, Urgent Care and Wound Management are not required to have 24-hour coverage.
16.
17. Molina may determine, in its sole discretion, that a practitioner is not eligible to apply for network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina Healthcare, who is currently in the Fair Hearing Process, or who is under investigation by Molina Healthcare. Molina Healthcare also may determine, in its sole discretion that a practitioner cannot continue network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina Healthcare. For purposes of this criteria, a company is "owned" by a practitioner when the practitioner has a majority financial interest in the company, through shares or other means.
18. Practitioners denied by the Credentialing Committee are not eligible to reapply until one year after the date of denial by the Credentialing Committee. At the time of reapplication, practitioner must meet all criteria for participation outlined above.
19. Practitioners terminated by the Credentialing Committee are not eligible to reapply until five years after the date of termination by the Credentialing Committee. At the time of reapplication, practitioner must meet all criteria for participation as outlined above.
20. Practitioners denied or terminated administratively are eligible to reapply for participation anytime as long as the practitioner meets all criteria for participation above.

Expedited Credentialing

For new providers joining a group practice already contracted with Molina Healthcare of Texas (MHT), MHT will offer expedited credentialing upon request and upon receipt of a completed credentialing application or attested CAQH number, and submission of all necessary elements to satisfy the credentialing requirement.

Burden of Proof

The practitioner shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina Healthcare network. This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a practitioner without limitation, including physical and mental health status as allowed by law, and the burden of resolving any doubts about these

or any other qualifications to participate in the Molina Healthcare network. If the practitioner fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina Healthcare network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

Practitioner termination and reinstatement

If a practitioner's contract is terminated and later it is determined to reinstate the practitioner, the practitioner must be initially credentialed prior to reinstatement if there is a break in service more than 30 calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Credentialing Committee's review must be re-verified. The Credentialing Committee or medical director, as appropriate, must review all credentials and make a final determination prior to the practitioner's reentry into the network.

If a practitioner is given administrative termination for reasons beyond Molina's control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, Molina may recredential the practitioner as long as there is clear documentation that the practitioner was terminated for reasons beyond Molina Healthcare's control and was recredentialed and reinstated within 30 calendar days of termination. Molina Healthcare must initially credential the practitioner if reinstatement is more than 30 calendar days after termination.

If Molina Healthcare is unable to recredential a practitioner within 36-months because the practitioner is on active military assignment, maternity leave or sabbatical but the contract between Molina and the practitioner remains in place, Molina Healthcare will recredential the practitioner upon his or her return. Molina Healthcare will document the reason for the delay in the practitioner's file. At a minimum, Molina Healthcare will verify that a practitioner who returns has a valid license to practice before he or she can resume seeing patients. Within 60 calendar days of notice when the practitioner resumes practice, Molina Healthcare will complete the recredentialing cycle. If either party terminates the contract and there is a break in service of more than 30 calendar days, Molina Healthcare will initially credential the practitioner before the practitioner rejoins the network.

Practitioners terminating with a delegate and contracting with Molina directly

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

Credentialing Application

At the time of initial credentialing and recredentialing, the practitioner must complete a credentialing application designed to provide Molina Healthcare with information necessary to perform a comprehensive review of the practitioner's credentials. The application must be completed in its entirety. The practitioner must attest that their application is complete and correct within 180 calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Pencils or erasable ink will not be an acceptable writing instrument for completing credentialing applications. Molina Healthcare may use another organization's application as long as it meets

all the factors outlined in this policy. Molina Healthcare will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. The attestation must include:

Reason for any inability to perform the essential functions of the position, with or without accommodation

Lack of present illegal drug use

History of loss of license and felony convictions

History of loss or limitation of privileges or disciplinary action

Current malpractice insurance coverage and

The correctness and completeness of the application

Inability to perform essential functions and illegal drug use

An inquiry regarding illegal drug use and inability to perform essential functions may vary. Practitioners may use language other than "drug" to attest they are not presently using illegal substances. Molina Healthcare may accept more general or extensive language to query practitioners about impairments; language does not have to refer exclusively to the present, or only to illegal substances.

History of actions against applicant

An application must contain the following information.

History of loss of license

History of felony convictions

History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a practitioner has had privileges

Current malpractice coverage

The application form must include specific questions regarding the dates and amount of a practitioner's current malpractice insurance. Molina may obtain a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the application.

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

Correctness and completeness of the application

Practitioners must attest that their application is complete and correct when they apply for credentialing and recredentialing. If a copy of an application from an entity external to Molina is used, it must include an attestation to the correctness and completeness of the application. Molina Healthcare does not consider the associated attestation elements as present if the practitioner did not attest to the application within the required time frame of 180 days. If state regulations require Molina Healthcare to use a credentialing application that does not contain an attestation, Molina Healthcare must attach an addendum to the application for attestation.

Meeting Application time limits

If the practitioner attestation exceeds 180 days before the credentialing decision, the practitioner must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the practitioner to update the attestation.

The Process for Making Credentialing Decisions

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

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

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

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

Once the application is received, Molina Healthcare will complete all the verifications as outlined in the attached Practitioner Criteria and Primary Source Verification Table. In order for the application to be deemed complete, the practitioner must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina Healthcare network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by Molina Healthcare must be provided.

If the practitioner does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina will discontinue processing of the application. This will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide proof of meeting the criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.

At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process each credentialing file is assigned a level based on established guidelines. Credentialing files assigned a level 1 are considered clean credentialing files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a level 2 are reviewed by the Molina Credentialing Committee.

At each Credentialing Committee meeting, practitioner credentialing files assigned a Level 2 are reviewed by the Credentialing Committee; all of the issues are presented to the Credentialing Committee members and then open discussion of the issues commences. After the discussion, the Credentialing Committee votes for a final decision. The Credentialing Committee can

approve, deny, terminate, approve on watch status, place on corrective action or defer their decision pending additional information.

Process for Delegating Credentialing and Recredentialing

Molina will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet Molina's requirements for delegation. Molina's Delegation Oversight Committee (DOC) must approve all delegation and subdelegation arrangements, and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet Molina's requirements.
Molina's Credentialing Committee retains the right to approve new providers and provider sites and terminate practitioners, providers and sites of care based on requirements in the Molina Credentialing Policy.

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

Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass Molina Healthcare's credentialing delegation pre-assessment, which is based on NCQA credentialing standards and requirements for the Medicaid and Medicare programs, with a score of at least 90%.

Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina Healthcare at pre-assessment

Agree to Molina Healthcare's contract terms and conditions for credentialing delegates

Submit timely and complete reports to Molina Healthcare as described in policy and procedure

Comply with all applicable federal and state laws

If the IPA or Provider Group subdelegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA certified in all ten areas of accreditation.

Non-Discriminatory Credentialing and Recredentialing

Molina Healthcare does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the practitioner specializes. This does not preclude Molina Healthcare from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

Notification of Discrepancies in Credentialing Information

Molina Healthcare will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license, malpractice claims

history or board certification decisions. Molina Healthcare is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law. Please also refer to the section below titled Practitioners Right to Correct Erroneous Information.

Notification of Credentialing Decisions

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

Confidentiality and Immunity

Information regarding any practitioner or provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under these Policies and Procedures. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a "Representative" shall mean any individual authorized to preform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section "information" may be any written or oral disclosures including, but not limited to, a practitioner's or provider's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or practitioner's or provider's provision of patient care services.

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

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the practitioner's or provider's qualifications.
2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal claims against any representative who acts in accordance with the provisions of this policy and procedure.
3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina membership and the continuation of such membership, and to the exercise of clinical privileges or provision of patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal law. To the fullest extent permitted by State or Federal law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

1. Any type of application or reapplication received by the Provider or Practitioner;

2. Actions reducing, suspending, terminating or revoking a practitioner's and provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
3. Hearing and appellate review;
4. Peer review and utilization and quality management activities;
5. Risk management activities and claims review;
6. Potential or actual liability exposure issues;
7. Incident and/or investigative reports;
8. Claims review;
9. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
10. Any activities related to monitoring the quality, appropriateness or safety of health care services;
11. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
12. Any Molina operations and actions relating to practitioner and provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a practitioner or provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a practitioner or provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the practitioner or provider, or if permitted or required by law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant state and federal law, and are not a limitation thereof.

All members (voting and non-voting) and guests of the Credentialing Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality annually. Members and guests of the Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at Molina.

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by law. Access to these documents are restricted to authorized staff, Credentialing Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of Molina. Each person is given a unique user ID and password. It is the strict policy of Molina that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three-months.

Minutes, reports and files of Credentialing Committee meetings are stored in secure electronic folders or in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable laws.

Copies of minutes and any other related Credentialing Committee meeting materials will not be allowed to be removed from meetings of peer review committees and Credentialing staff will shred extra sets of information from such meetings. Electronic data and/or information are password protected and Molina Staff is instructed not to divulge passwords to their co-workers.

Practitioners Rights during the Credentialing Process

Practitioners have the right to review their credentials file at any time. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

The practitioner must notify the Credentialing Department and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the practitioner are documents which the practitioner sent to Molina (e.g., the application, the license and a copy of the DEA certificate). Practitioners may not copy documents that include pieces of information that are confidential in nature, such as the practitioner credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, State Licensing Board), and verification of hospital privileges letters.

Practitioners Right to Correct Erroneous Information

Practitioners have the right to correct erroneous information in their credentials file. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

Molina will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license or malpractice claims history. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

The notification sent to the practitioner will detail the information in question and will include instructions to the practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina.

- In their response, the practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.

The practitioner's response must be sent to Molina Healthcare, Inc. Attention Kari Horseman, CPCS, Credentialing Director at PO Box 2470 Spokane WA 99210

Upon receipt of notification from the practitioner, Molina will document receipt of the information in the practitioners credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioners credentials file. The practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with practitioners' notification, the Credentialing Department will notify the practitioner. The practitioner may then provide proof of correction by the primary source body to Molina's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the practitioner does not respond within 10 calendar days, their application processing will be discontinued and network participation will be denied.

Practitioners Right to be Informed of Application Status

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

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

Credentialing Committee

Molina designates a Credentialing Committee to make recommendations regarding credentialing decisions using a peer review process. Molina works with the Credentialing Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to Molina members. A practitioner may not provide care to Molina members until the final decision from the Credentialing Committee or in situations of "clean files" the final decision from the Molina Medical Director.

The Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicant practitioners and for approving or denying applicants for participation. In addition, the Credentialing Committee reviews Credentialing Policies and Procedures annually and recommends revisions, additions and/or deletions to the policies and procedures. Composed of network practitioners, the committee is responsible for performing peer review of medical information when requested by the Medical Director, and recommending actions based on peer review findings, if needed. The committees report to the Quality Improvement Committee (QIC).

Each Credentialing Committee member shall be immune, to the fullest extent provided by law, from liability to an applicant or practitioner for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

Committee Composition

The Medical Director chairs the Credentialing Committee and appoints all Credentialing Committee members. Each member is required to meet all of Molina's credentialing criteria. Credentialing Committee members must be current representatives of Molina's practitioner network. The Credentialing Committee representation includes at least five practitioners. These may include practitioners from the following specialties:

Family Medicine

Internal Medicine

Pediatrics

OB/GYN

Surgery

Additionally, surgical specialists and Internal Medicine specialists may participate on the committee as appropriate. Other ad hoc practitioners may be invited to participate when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Behavioral Health Practitioner, Nurse Practitioners, Chiropractors) may be appointed by the chairs to screen applicants from their respective profession and make credentialing recommendations to the Credentialing Committee.

Committee Members Roles and Responsibilities

Committee members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.

Review/approve credentialing program policy and related policies established by Molina Healthcare on an annual basis, or more often as deemed necessary.

Review and consider each applicant’s information based on criteria and compliance requirements. The Credentialing Committee votes to make final decisions regarding credentialing determinations and disciplinary actions.

Conduct ongoing monitoring of those practitioners approved to be monitored on a “watch status”

Access clinical peer input when discussing standards of care for a particular type of practitioner when there is no committee member of that specialty.

Ensure credentialing activities are conducted in accordance with Molina's Credentialing Program.

Review quality improvement findings as part of the recredentialing and the ongoing monitoring process.

Excluded Practitioners

Excluded practitioner means an individual practitioner, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina Healthcare and its subcontractors may not subcontract with an Excluded Practitioner/Person. Molina Healthcare and its subcontractors shall terminate subcontracts immediately when Molina Healthcare and its subcontractors become aware of such excluded practitioner/person or when Molina Healthcare and its subcontractors receive notice. Molina Healthcare and its subcontractors certify that neither it nor its member/practitioner is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina Healthcare and its subcontractors are unable to certify any of the statements in this certification, Molina Healthcare and its subcontractors shall attach a written explanation to this Agreement.

Practitioners/Providers opting out of Medicare

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

Ongoing Monitoring of Sanctions

Molina monitors practitioner sanctions between recredentialing cycles for all practitioner types and takes appropriate action against practitioners when occurrences of poor quality is identified.

Medicare and Medicaid sanctions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. Within 30 calendar days of its release, Molina reviews the report and if a Molina network provider is found with a sanction, the practitioner's contract is terminated effective the same date the sanction was implemented.

Sanctions or limitations on licensure

Molina monitors for sanctions or limitations against licensure between credentialing cycles for all network practitioners. All practitioners with identified sanctions or limitations on license in the ongoing monitoring process will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialing process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Continuous Query (Proactive Disclosure Service)

Molina registers all network practitioners with the NPDB/HIPDB Continuous Query program. Molina receives instant notification of all new NPDB and HIPDB reports against the enrolled providers. When a new report is received between recredentialing cycles, the practitioner will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialing process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Medicare Opt-Out

Practitioner's participating in Medicare must not be listed on the Medicare Opt-Out report. Molina Healthcare reviews the quarterly opt out reports released from the appropriate Medicare financial intermediary showing all of the practitioners who have chosen to Opt-Out of Medicare. These reports are reviewed within 30 calendar days of their release. If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. These provider contracts will be immediately terminated for the Molina Medicare line of business.

Range of Actions, Notification to Authorities and Practitioner Appeal Rights

Molina uses established criteria in the review of practitioners' performance. All adverse actions taken by the Credentialing Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986.

Range of actions available

The Molina Credentialing Committee can take one of the following actions against practitioners who fail to meet credentialing standards or who fail to meet performance expectations pertaining to quality of patient care:

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

This applies to all practitioners who are contracted by Molina Healthcare. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. The purpose of this policy is to provide a mechanism for implementation of monitoring on watch status, requiring formal corrective action, suspension or termination of Molina Healthcare practitioners.

If at any point a practitioner fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of patient care the Credentialing Committee may act to implement one of these actions. Termination may be taken after

reasonable effort has been made to obtain all the facts of the matter and the practitioner may be given the opportunity to appeal this decision.

Criteria for Denial or Termination Decisions by the Credentialing Committee

The criteria used by the Credentialing Committee to make a decision to deny or terminate a practitioner from the Molina network include, but are not limited to, the following:

1. The practitioner's professional license in any state has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
2. Practitioner has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the practitioner's acts, omissions or conduct.
3. Practitioner has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any state or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the practitioner to Molina members.
4. Practitioner has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their federal Drug Enforcement Agency (DEA) certificate or Controlled Substance Certification or Registration.
5. Practitioner has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the practitioner has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the practitioner has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the practitioner's practice.
6. Practitioner has ever had sanctions of any nature taken by any governmental program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or agency
7. Practitioner has ever had any denials, limitations, suspensions or terminations of participation of privileges by any health care institution, plan, facility or clinic.
8. Practitioner's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
9. Practitioner has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
10. Practitioner has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the practitioner's professional conduct or the health, safety or welfare of Molina members
11. Practitioner has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.
12. Practitioner has a pattern of member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina members.
13. Practitioner has not complied with Molina's quality assurance program.
14. Practitioner is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.

15. Practitioner has displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Practitioner makes any material misstatements in or omissions from their credentialing application and attachments.
17. Practitioner has ever rendered services outside the scope of their license.
18. Practitioner has a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
19. Practitioner's failure to comply with the Molina Medical Record Review Guidelines.
20. Practitioner's failure to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring on a Committee Watch Status

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

When a practitioner is approved on watch status, the Credentialing Department conducts the follow-up according to the Credentialing Committee direction. Any unusual findings are reported immediately to the Molina Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Credentialing Committee meeting for review and determination.

Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, Molina may work with the practitioner to establish a formal corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

A corrective action plan is a written improvement plan, which may include, but is not limited to the following:

Identifying the performance issues that do not meet expectations

What actions/processes will be implemented for correction

Who is responsible for the corrective action

What improvement/resolution is expected

How improvements will be assessed

Scheduled follow-up, monitoring (compliance review, normally not to exceed six months)

Practitioners subject to corrective action will be notified within ten (10) calendar days, via a certified letter from the Medical Director. Such notification will outline:

The reason for the corrective action

The corrective action plan

If the corrective actions are resolved, the practitioner's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing Committee may recommend that the practitioner continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate practitioner response to corrective action will be brought to the Credentialing Committee for review and decision.

Summary Suspension

In cases where the Medical Director becomes aware of circumstances that pose an immediate risk to patients, a meeting will be held immediately with Molina Legal Counsel, the Medical Director and the Director of Credentialing. After discussing the facts, the practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Medical Director shall promptly notify the practitioner of the suspension, via a certified letter. Notification will include the following:

The action being taken

Effective date of the action

The reason(s) for the action and/or information being investigated

Information (if any) required from the practitioner

The estimated timeline for determining whether or not to reinstate or terminate the practitioner

Details regarding the practitioners right to request a fair hearing within 30 calendar days (see Fair Hearing Plan policy) and their right to be represented by an attorney or another person of their choice

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing Committee. The Credentialing Committee has the authority to implement corrective action, place conditions on the practitioner's continued participation, discontinue the suspension or terminate the practitioner.

Terminations based on unprofessional conduct or quality of care

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

Within ten (10) calendar days of the Committee's decision, the practitioner is sent a written notice of Molina's intent to terminate them from the network, via certified mail from the Medical Director, which includes the following:

A Description of the action being taken

Reason for termination

Details regarding the practitioner's right to request a fair hearing within 30 calendar days of receipt of notice (see Fair Hearing Plan policy). The Fair Hearing Policy explains that Molina will appoint a hearing officer and a panel of individuals to review the appeal.

The practitioner does not request a fair hearing within the 30 calendar days, they have waived their rights to a hearing.

The notice will include a copy of the Fair Hearing Plan Policy describing the process in detail.

Practitioner's right to be represented by an attorney or another person of their choice.

Obligations of the practitioner regarding further care of Molina patients/members

The action will be reported to the NPDB and the State Licensing Board.

Molina will wait 30 calendar days from the date the terminated practitioner received the notice of termination. If the practitioner requests a fair hearing within that required timeframe, Molina will follow the Fair Hearing Plan Policy. Once the hearing process is completed, the practitioner will receive written notification of the appeal decision which will contain specific reasons for the decision (see Fair Hearing Plan Policy). If the hearing committee's decision is to uphold the termination, the action will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below. If the hearing committee overturns the termination decision and the practitioner remains in the Molina network, the action will not be reportable to the State Licensing Board or to the NPDB.

If the practitioner does not request a hearing within the 30 calendar days, they have waived their rights to a hearing and the termination will become the final decision. A written notification of the final termination will be sent to the practitioner and the termination will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below.

Reporting to Appropriate Authorities

Molina will make reports to appropriate authorities as specified in the Fair Hearing Plan Policy when the Credentialing Committee takes or recommends certain Adverse Actions for a practitioner based upon Unprofessional Conduct or quality of care. Adverse Actions include:

Revocation, termination of, or expulsion from Molina Provider status.

Summary Suspension in effect or imposed for more than thirty (30) calendar days.

Any other final action by Molina that by its nature is reportable to the State Licensing Board and the NPDB.

Within 15 calendar days of the effective date of the final action, the Manager responsible for credentialing reports the action to the following authorities:

All appropriate state licensing agencies

- National Practitioner Data Bank (NPDB)

A letter is then written to the appropriate state licensing boards describing the adverse action taken, the practitioner it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate state licensing boards within 24-hours of receiving the final NPDB report. A copy of this letter is filed into the Practitioner's credentials file.

The action is also reported to the applicable Molina Government Compliance Department within 15-calendar days of the effective date of the action. The Government Compliance Department is then responsible for notifying other state agencies as required in the contracts between Molina and the State entities.

Fair Hearing Plan Policy

Under State and Federal law, certain procedural rights shall be granted to a provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board, the National Practitioner Data Bank ("NPDB"), and/or the Healthcare Integrity and Protection Data Bank ("HIPDB").

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

A. Definitions

1. Adverse Action shall mean an action that entitles a provider to a hearing, as set forth in Section B (l)-(3) below.

2. Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina affiliate state plan wherein the provider is contracted.

3. Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.

4. Medical Director shall mean the Medical Director for the respective Molina affiliate state plan wherein the provider is contracted.

5. Molina Plan shall mean the respective Molina affiliate state plan wherein the provider is contracted.

6. Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.

7. Peer Review Committee or Credentialing Committee shall mean a Molina Plan committee or the designee of such a committee.

8. Plan President shall mean the Plan President for the respective Molina affiliate state plan wherein the provider is contracted.

9. Provider shall mean physicians, dentists, and other health care practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).

10. State shall mean the licensing board in the state in which the provider practices.

11. State Licensing Board shall mean the state agency responsible for the licensure of provider.

12. Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a provider violates a material term of the provider's contract with a Molina Plan.

B. Grounds for a Hearing

Grounds for a hearing exist whenever the Peer Review Committee or Credentialing Committee takes or recommends any of the following Adverse Actions for a provider based upon Unprofessional Conduct:

1. Revocation, termination of, or expulsion from Molina Provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board, NPDB, and/or HIPDB.

2. Suspension, reduction, limitation, or revocation of authority to provide care to Molina members when such suspension, reduction, limitation, or revocation is reportable to the State Licensing Board, NPDB, and/or HIPDB.

3. Any other final action by Molina that by its nature is reportable to the State Licensing Board, NPDB, and/or HIPDB.

C. Notice of Action

If the Peer Review Committee and/or Credentialing Committee have recommended an Adverse Action, the Committee shall give written notice to the provider by certified mail with return receipt requested. The notice shall:

1. State the reasons for the action;

2. State any Credentialing Policy provisions that have been violated;

3. Advise the provider that he/she has the right to request a hearing on the proposed Adverse Action;

4. Advise the provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective Molina Plan Medical Director by certified mail, return receipt requested, or personal delivery;

5. Advise the provider that he/she has the right to be represented by an attorney or another person of their choice.

6. Advise the provider that the request for a hearing ***must*** be accompanied by a check in the amount of $1,000.00 as a deposit for the administrative expenses

of the hearing and specify that this amount will be refunded if the Adverse Action is overturned;

7. State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal law; and

8. Provide a summary of the provider's hearing rights or attach a copy of this Policy.

D. Request for a Hearing - Waiver

If the provider does not request a hearing in writing to the Chief Medical Officer within thirty (30) days following receipt of the Notice of Action, the provider shall be deemed to have accepted the action or recommendation of the Peer Review Committee and/or Credentialing Committee, and such action or recommendation shall be submitted to the Chief Medical Officer for final decision. In the event that a timely written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Peer Review Committee and/or Credentialing Committee shall provide the provider with a Notice of Hearing and Statement of Charges consistent with this Policy.

A provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing to which he or she might otherwise have been entitled. If the provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action shall be forwarded to the Chief Medical Officer for final approval. In the event of a submittal to the Chief Medical Officer upon the provider's waiver as set forth herein, the Peer Review Committee and/or Credentialing Committee may submit to the Chief Medical Officer additional information relevant to its recommended Adverse Action to be considered by the Chief Medical Officer in accepting or rejecting the recommended Adverse Action.

E. Appointment of a Hearing Committee

1. Composition of Hearing Committee

The Chief Medical Officer/Plan President shall select the individuals to serve on the Hearing Committee. The Hearing Committee shall consist of individuals who are not in direct economic competition with the subject provider; who shall gain no direct financial benefit from the outcome of the hearing; and, who shall have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. General knowledge of the matter involved shall not preclude a physician from serving as a member of the panel.

The panel shall consist of three or more providers and shall include, whenever feasible, at least one individual practicing the same specialty as the affected provider. In the event providers are not available to sit as Hearing Committee members, physicians from the community may be substituted by the Medical Director.

2. Scope of Authority

The Hearing Committee shall have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.

3. Responsibilities

The Hearing Committee shall:

a. Evaluate evidence and testimony presented.

b. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.

c. Maintain the privacy of the hearing unless the law provides to the contrary.

4. Vacancies

In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.

5. Disclosure and Challenge Procedures

Any person appointed to the Hearing Committee shall disclose to the Chief Medical Officer/Plan President any circumstance likely to affect impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives. The Hearing Officer may remove any person appointed to the Hearing Committee if the Hearing Officer believes that the person is unable to render an impartial decision.

F. Hearing Officer

1. Selection

The Chief Medical Officer and/or Plan President shall appoint a Hearing Officer, who may be an attorney. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

2. Scope of Authority

The Hearing Officer shall have the sole discretion and authority to:

a. Exclude any witness, other than a party or other essential person.

b. Determine the attendance of any person other than the parties and their counsel and representatives.

c. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative, and shall also grant such postponement when all of the parties agree thereto.

3. Responsibilities

The Hearing Officer shall:

a. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;

b. Ensure that proper decorum is maintained;

c. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;

d. Issue rulings pertaining to matters of law, procedure and the admissibility of evidence;

e. Issue rulings on any objections or evidentiary matters;

f. Discretion to limit the amount of time;

g. Assure that each witness is sworn in by the court reporter;

h. May ask questions of the witnesses (but must remain neutral/impartial);

i. May meet in private with the panel members to discuss the conduct of the hearing;

j. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;

k. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and

l. Prepare the written report.

G. Time and Place of Hearing

Upon receipt of a Request for Hearing, the Chief Medical Officer and/or Plan President shall schedule and arrange for a hearing. The Chief Medical Officer and/or Plan President shall give notice to the affected provider of the time, place and date of the hearing, as set forth below. The date of commencement of the hearing shall be not less than thirty (30) days from the date of the Notice of the Hearing, and not more than sixty (60) days from the date of receipt of the Request for Hearing. Notwithstanding the above timeframes, the parties may agree to extensions, or the Hearing Officer may grant an extension on a showing of good cause. If more than one meeting is required for a hearing, the Hearing Officer shall set the date, time, and location for additional meetings.

H. Notice of Hearing

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

1. The date, time and location of the hearing.

2. The name of the Hearing Officer.

3. The names of the Hearing Committee Members.

4. A concise statement of the affected provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.

5. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.

6. A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the provider to prepare a defense, including all documentary evidence which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.

Except with regard to the disclosure of witnesses, as set forth above, the Notice of Hearing may be amended from time to time, but not later than the close of the case at the conclusion of the hearing by the Hearing Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

I. Pre-Hearing Procedures

1. The provider shall have the following pre-hearing rights:

   a. To inspect and copy, at the provider's expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and

   b. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.

2. The Hearing Committee shall have the following pre-hearing right:

   To inspect and copy, at Molina's expense, any documents or other evidence relevant to the charges which the provider has in his or her possession or control as soon as practicable after receiving the hearing request.

3. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:

    a. Whether the information sought may be introduced to support or defend the charges;

    b. The exculpatory or inculpatory nature of the information sought, if any;

    c. The burden attendant upon the party in possession of the information sought if access is granted; and

    d. Any previous requests for access to information submitted or resisted by the parties.

4. The provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

5. It shall be the duty of the provider, the Peer Review Committee and/or Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

6. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.

7. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of State.

J. Conduct of Hearing

1. Rights of the Parties

    Within reasonable limitations, and as long as these rights are exercised in an efficient and expeditious manner, both sides at the hearing may:

    a. Call and examine witnesses for relevant testimony.

    b. Introduce relevant exhibits or other documents.

    c. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.

d. Otherwise rebut evidence.

e. Have a record made of the proceedings.

f. Submit a written statement at the close of the hearing.

g. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

The provider may be called by the Peer Review Committee and/or Credentialing Committee and examined as if under cross-examination.

2. Course of the Hearing

a. Each party may make an oral opening statement.

b. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.

c. The affected provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.

d. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.

e. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.

3. Use of Exhibits

a. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.

b. A description of the exhibits in the order received shall be made a part of the record.

4. Witnesses

a. Witnesses for each party shall submit to questions or other examination.

b. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.

c. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.

d. The party producing such witnesses shall pay the expenses of their witnesses.

5. Rules for Hearing:

a. Attendance at Hearings

Only those persons having a direct interest in the hearing are entitled to attend the hearing. This means that the hearing will be closed except for the parties and their representatives. The only exception is when good cause is shown satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the hearing to have others present.

b. Communication with Hearing Committee

There shall be no direct communication between the parties and the Hearing Committee other than at the hearing, unless the parties and the Hearing Committee agree otherwise. Any other oral or written communication from the parties to the Hearing Committee shall be directed to the Hearing Officer for transmittal to the Hearing Committee.

c. Interpreter

Any party wishing to utilize an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

K. Close of the Hearing

At the conclusion of the hearing, the Hearing Officer shall dismiss all parties and participate in the deliberations of the Hearing Committee. The Hearing Committee shall render its final decision by a majority vote, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached to the Hearing Officer.

Within thirty (30) days of the conclusion of the deliberations, the Hearing Officer shall issue a written report including the following:

1. A summary of facts and circumstances giving rise to the hearing.

2. A description of the hearing, including:

a. The panel members' names and specialties;

b. The Hearing officer's name;

c. The date of the hearing;

d. The charges at issue; and

e. An overview of witnesses heard and evidence.

3. The findings and recommendations of the Hearing Committee.

4. Any dissenting opinions desired to be expressed by the hearing panel members.

Final adjournment of the Hearing Committee shall occur when the Hearing Officer has mailed or otherwise delivered the written report.

L. Burden of Proof

In all hearings it shall be incumbent on the Peer Review Committee and/or Credentialing Committee taking or recommending an Adverse Action to come forward initially with evidence in support of its action or decision. Thereafter, the provider who requested the hearing shall come forward with evidence in his/her support.

The burden of proof during a hearing shall be as follows:

The Peer Review Committee or Credentialing Committee taking or recommending the Adverse Action shall bear the burden of persuading the Hearing Committee that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of alternatives reasonably available to the Peer Review Committee and/or Credentialing Committee taking or recommending Adverse Action under the circumstances and not necessarily that the action or recommendation is the only measure or the best measure that could have been taken or formulated.

M. Provider Failure to Appear or Proceed

Failure, without good cause, of the provider to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

N. Record of the Hearing/Oath

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by Molina, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer shall be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

O. Representation

Each party shall be entitled to representation by an attorney at law, or other representative at the hearing, at their own expense, to represent their interests, present their case, offer materials in support thereof, examine witnesses, and/or respond to appropriate questions.

P. Postponements

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

Q. Notification of Finding

The Hearing Office shall serve a copy of the written report outlining the basis of the Hearing Committee's decision to the Medical Director, the Peer Review Committee and/or Credentialing Committee imposing the Adverse Action, and the affected provider.

R. Final Decision

Upon receipt of the Hearing Committee's decision, the Chief Medical Officer/Plan President shall either adopt or reject the Hearing Committee's decision. The Chief Medical Officer/Plan President's action constitutes the final decision.

S. Reporting

In the event the Chief Medical Officer/Plan President adopts the proposed decision of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action, Molina will submit a report to the State Licensing Board, NPDB, and/or HIPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

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

T. Exhaustion of Internal Remedies

If any of the above Adverse Actions are taken or recommended, the provider must exhaust the remedies afforded by this Policy before resorting to legal action.

U. Confidentiality and Immunity

Information regarding any practitioner or provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under these Policies and Procedures. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a "Representative" shall mean any individual authorized to preform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section "information" may be any written or oral disclosures including, but not limited to, a practitioner's or provider's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or practitioner's or provider's provision of patient care services.

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

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the practitioner's or provider's qualifications.
2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal claims against any representative who acts in accordance with the provisions of this policy and procedure.
3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina membership and the continuation of such membership, and to the exercise of clinical privileges or provision of patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal law. To the fullest extent permitted by State or Federal law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

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

Immunity from Liability for Action Taken: No representative shall be liable to a practitioner or provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a practitioner or provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the practitioner or provider, or if permitted or required by law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to

other protections provided by relevant state and federal law, and are not a limitation thereof.

Section 13. Complaints and Appeals Process

Provider Claims Reconsideration Dispute

The processing, payment or nonpayment of a claim by Molina Healthcare of Texas shall be classified as a Provider Dispute and shall be sent to the following address:

Molina Healthcare of Texas
Attention: Provider Claims Disputes
15115 Park Row Blvd., Suite 110

Houston, TX 77084

Reporting

All Complaints/Appeal data, including practitioner specific data, is reported quarterly to Member/Provider Satisfaction Committee by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to the Member/Provider Satisfaction Committee (MPSC) and EQIC by the chairman of MPSC to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement.

Appeals and Complaints will be reported to the State quarterly. Complaints and Appeals reports will be reviewed monthly by the Credentialing Coordinator for inclusion in the trending of ongoing sanctions, complaints and quality issues.

Record Retention

Molina Healthcare of Texas will maintain all complaints and related appeal documentation on file for a minimum of six (6) years. In addition to the information documented electronically via Call Tracking in QNXT or maintained in other electronic files, Molina Healthcare of Texas will retain copies of any written documentation submitted by the provider pertaining to the complaints/appeal process. Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Health Plan's prior approval for the disposition of records if Agreement is continuous.)

Complaints and Appeals

Definitions

Complainant (1) means a Member or a treating provider or other individual designated to act on behalf of the Member who filed the Complaint. (2) A Provider who has filed a complaint

Member Appeal is a formal process by which a Member or his/her representative requests a review of the MHT's Action.

Member Inquiry is a request for information that is resolved promptly by providing the appropriate information; or a misunderstanding that is cleared up to the satisfaction of the Member.

Provider Complaint means an expression of dissatisfaction expressed by a provider, orally or in writing to the MHT, about any matter related to the MHT other than a determination of medical necessity for a service. A provider complaint does not include a matter of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information to the provider's satisfaction.

Provider Inquiry is a request for information that is resolved promptly by providing the appropriate information; a misunderstanding that is cleared up to the satisfaction of the Provider.

***Provider Claims Reconsideration** is a dispute or request from a provider to review a claim denial or partial payment. Claim reconsideration includes, but is not limited to, timely filing, contractual payment issues etc.

Provider Claims Appeal is a written request for review of a claim denial or partial payment. All claim appeals must be clearly identified as "Provider Claims Appeal" by written request and be accompanied with all necessary documentation which may include but is not limited to, medical records or if claim was previously reviewed through the reconsideration process.

***Molina would encourage providers to submit claims reconsideration prior to submitting a formal written claims appeal.

Provider Appeals

Appeal Process

Appeal means the formal process by which a Provider requests a review of the MHT's Action.

Action means:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial in whole or in part of payment for services;
- The failure to provide services in a timely manner;
- The failure of an MHT to act within the timeframes set forth in the contract;

How to file an appeal:

- An appeal must be submitted in writing to:

MOLINA
Write to: Molina Health Care of Texas Attention: Appeals Dept. 15115 Park Row Blvd., Suite 110 Houston, TX 77084

Appeal Timeframes:

- The provider or practitioner is allowed **120 days** from the date of the initial denial notification to submit a first level appeal.
  - Provider or Practitioner appeal of a Utilization Management (UM) decision shall be adjudicated in a thorough, appropriate, and timely manner

- A first level appeal for decisions made by Molina Utilization Management shall be reviewed by a Medical Director not involved in the initial denial decision.
- The provider or practitioner is allowed **thirty (30) days** from the first level appeal decision notification to submit a second level appeal.
- A second level appeal of a first level appeal decision may be made by a Molina Healthcare Medical Director or an independent reviewer for reconsideration.

Provider Complaints

A provider has the right to file a complaint with Molina Healthcare at any time. The provider also has the right to file a complaint directly with Texas Department of Insurance (TDI).

How to file a Complaint:

- A complaint can be oral or written:

MOLINA	TDI
Call: 1-888-560-2025	**Call:** 1-800-252-3439
Write to: Molina Health Care of Texas Attention: Complaints Dept. 15115 Park Row Blvd., Suite 110 Houston, TX 77084	**Write to:** TDI Consumer Protection (111-1A) Po Box 149091 Austin, Texas 78714-9091

Complaint Timeframes:

- A provider can file a complaint anytime.
- Complaints will be investigated, addressed, and the provider will be notified of the outcome, in writing, within 30 calendar days from the date the complaint is received by Molina Healthcare.

Section 14. Medical Group/IPA Operations and Delegation

This section contains information specific to medical groups, Independent Practice Associations (IPA), and Vendors contracted with Molina Healthcare to provide medical care or services to members, and outlines Molina Healthcare's delegation criteria and capitation reimbursement models. Molina Healthcare will delegate certain administrative responsibilities to the contracted medical groups, IPAs, or vendors, upon meeting all of Molina Healthcare's delegation criteria. Provider capitation reimbursement models employed by Molina Healthcare range from fee-for-service to full risk capitation.

Delegation of Administrative Functions

Administrative services which may be delegated to IPAs, medical groups, or other organizations include but not limited to the following:

- Claims payment
- Credentialing
- Transportation
- Utilization Management (UM)

Credentialing functions may be delegated to capitated or non-capitated entities, which meet NCQA criteria for credentialing functions. Utilization Management (UM) and/or Claims payment responsibility is generally only delegated to capitated entities. Transportation may be delegated to Vendors who can meet Transportation, as well as Claims Payment requirements.

Note: The member's Molina Healthcare ID card will identify which group the member is assigned. If Claims payment and/or UM has been delegated to the group, the ID card will show the delegated group's remit to address and phone number for referrals and prior authorizations (See section 2.)

For a quick reference, the following table reflects the Claims and Referral/Authorization contact information for all medical groups/IPAs currently delegated for Claims payment and/or UM functions.

Medical Group/IPA Full Name	ID card Acronym	Claims Remit to Address	UM Referral/ Authorization Phone #
Liberty Dental			
Total Vision Opticare			

Delegation Criteria

Molina Healthcare is accountable for all aspects of the member's health care delivery, even when it delegates specific responsibilities to sub-contracted medical groups, IPAs, or Vendors.

Molina Healthcare's Delegation Oversight Committee (DOC) must approve all delegation and sub-delegation arrangements.

Credentialing

To be delegated for credentialing, medical groups or IPAs must:

- Be accredited by the National Committee for Quality Assurance (NCQA) for credentialing or pass Molina Healthcare's credentialing pre-assessment, which is based on NCQA credentialing standards, with a score of at least 90%
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for credentialing delegates
- Submit timely and complete credentialing reports to Molina Healthcare
- Comply with all applicable federal and state laws
- When key specialists, as defined by Molina Healthcare, contracted with IPA or group terminate, provide Molina Healthcare with a letter of termination according to contractual agreements and the information necessary to notify affected members

Note: If the medical group/IPA sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions, or demonstrate and ability to meet all Health Plan, NCQA, and State and Federal requirements identified above. Evaluation should be done prior to execution of a contract, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, and a process to implement corrective action if issues of non-compliance are identified..

A medical group/IPA may request credentialing delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by the medical group/IPA's Contract Manager). Molina Healthcare will ask the potential delegate to submit policies and procedures and all applicable documents for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are presented to the Delegation Oversight Committee for review and approval. Final decision to delegate the credentialing process is based on the medical group/IPAs ability to meet Molina Healthcare's standards and criteria for delegation.

Utilization Management

To be delegated for UM, medical groups or IPAs must:

- Have a UM program that has been operational at least one year prior to delegation
- Be NCQA accredited for utilization management or pass Molina Healthcare's UM pre-assessment, which is based on NCQA UM standards, with a score of at least 90%
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare

- Agree to Molina Healthcare's contract terms and conditions for UM delegates
- Submit timely and complete UM delegate reports to Molina Healthcare
- Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA
- Comply with all applicable federal and state laws

Note: Molina Healthcare does not allow UM delegates to further sub-delegate UM activities.

A medical group or IPA may request UM delegation from Molina Healthcare through Molina Healthcare's Provider Services Contract Manager. Molina Healthcare will ask the potential delegate to submit policies and procedures and all applicable documents for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are presented to the Delegation Oversight Committee for review and approval. Final decision to delegate UM is based on the medical group or IPAs ability to meet Molina Healthcare's standards and criteria for delegation.

Claims

To be delegated for Claims, IPAs, Provider Groups, and Vendors must do the following:

- Have a capitation contract with Molina Healthcare and be in compliance with the financial reserves requirements of the contract
- Except for Transportation Vendors, be delegated for UM by Molina Healthcare
- Pass Molina Healthcare's claims pre-assessment, which is based on State and Federal Claims Payment standards.
- Have an automated Claims payment system with eligibility, authorization, and Claims adjudication
- Have a Claims delegation pre-assessment completed by Molina Healthcare to determine compliance with all regulatory requirements for Claims payment, such as the Claims for emergency services, and the payment of interest on Claims not paid within Texas regulated timeframes
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Protect the confidentiality of all Claims information as required by law
- Have a system capable of providing Molina Healthcare with the encounter data required by the state in a format readable by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for Claims delegates
- Submit timely and complete Claims delegate reports to Molina Healthcare
- Within (45) days of the end of the month in which care was rendered, provide Molina Healthcare with the encounter data required by the state in a format compliant with HIPAA requirements
- Provide additional information as necessary to load encounter data within (30) days of Molina Healthcare's request

- Comply with the standard Transactions and Code Sets requirements for accepting and sending electronic health care Claims information and remittance advice statements using the formats required by HIPAA

- Comply with all applicable federal and state laws

- When using Molina Healthcare's contract terms to pay for services rendered by providers not contracted with IPA or group, follow Molina Healthcare's Claims policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims

Note: Molina Healthcare does not allow Claims delegates to further sub-delegate Claims activities.

A medical group/IPA may request Claims delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by the medical group/IPA's Contract Manager). Molina Healthcare will ask the potential delegate to submit policies and procedures and all applicable documents for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are presented to the Delegation Oversight Committee for review and approval. Final decision to delegate Claims is based on the medical group/IPA's ability to meet Molina Healthcare's standards and criteria for delegation.

Transportation

Transportation may be delegated to State or National Vendors who demonstrate compliance with the following requirements:

- Pass Molina Healthcare's Transportation pre-assessment, which is based on State and Federal Transportation requirements, with a score of at least 90%

- Have automated systems that allow for scheduling of transportation appointments, confirmation of member eligibility, and availability of transportation benefits.

- Have processes in place to ensure protection of member PHI.

- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.

- Have a network of vehicles and drivers that meet state and federal safety requirements.

- Ensure on at least an annual basis that vehicles continue to meet state and federal vehicle safety requirements.

- Ensure that drivers continually meet state and federal safety requirements.

- Have a process in place for reporting of all accidents, regardless of harm to member, to Molina Healthcare within 48 hours.

- Agree to Molina Healthcare's contract terms and conditions for Transportation delegates, including applicable Claims delegation requirements.

- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare

- Submit timely and complete Transportation delegation reports to Molina Healthcare
- Comply with all applicable federal and state laws

Note: If the Transportation Vendor delegates to other sub-contractors, the Transportation Vendor must have a process to ensure that their sub-contractors meet all Health Plan and State and Federal requirements identified above. Evaluation should be done prior to execution of a contract, and annually thereafter. Evaluation should include review of compliance with driver requirements, vehicle requirements, Health Plan, State and Federal requirements, and a process to implement corrective action if issues of non-compliance are identified.

A Vendor may request Transportation delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by the Vendor's Contract Manager). Molina Healthcare will ask the potential delegate to submit policies and procedures and all applicable documents for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are presented to the Delegation Oversight Committee for review and approval. Final decision to delegate Transportation is based on the vendor's ability to meet Molina Healthcare's standards and criteria for delegation.

Quality Improvement/Preventive Health Activities

Molina Healthcare will not delegate quality improvement to provider organizations. Molina Healthcare will include all network providers, including those in medical groups/IPAs who are delegated for other functions (Claims, Credentialing, UM) in its quality improvement program activities and preventive health activities. Molina Healthcare encourages all contracted provider organizations to conduct activities to improve the quality of care and service provided by their organization. Molina Healthcare would appreciate receiving copies of studies conducted or data analyzed as part of the medical group/IPAs quality improvement program.

Delegation Reporting Requirements

Medical groups, IPAs, or Vendors, contracted with Molina Healthcare and delegated for various administrative functions must submit monthly reports to the identified Molina Healthcare Delegation Oversight Staff within the timeline indicated by the health plan. For a copy of Molina Healthcare's current delegation reporting requirements, please contact your Molina Healthcare Provider Services Contract Manager.

Section 15. Cultural Competency

Background

The Cultural Competency Plan exists to ensure the delivery of culturally competent services and ensure the provision of Linguistic Access and Disability-related Access to all members including those with limited English Proficiency. The plan is based on guidelines outlined in National Standards for culturally and Linguistically Appropriate Services (CLAS) in Health Care, published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH). The Cultural Competency Plan describes how the individuals and systems within the Organization will effectively provide services to people of all cultures, races, ethnic backgrounds and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Training of employees and providers, and quality monitoring are the cornerstones of successful culturally competent service delivery. For that reason, the cultural competency program is integrated into the overall provider training and quality monitoring programs. An integrated quality approach is aimed at enhancing the way people think about our members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

Molina Healthcare offers educational opportunities in cultural competency concepts for providers on a regular basis. This is a summary of the Cultural Competency Plan; providers may use links on the Molina Healthcare website to obtain the full Cultural Competency Plan.

Cultural Competency trainings are offered to providers and supporting staff. Cultural Competency Training programs are also available to Community Based Organizations.

Provider training is conducted concurrent with and integrated into provider orientation with annual reinforcement training. Additional training reinforcement is provided through continuing medical education (CME) monographs developed by the health plan, and periodically accompanying provider communications. Training is provided in modules delivered through a variety of methods including, but not limited to, one or more of the following:

1. Written materials – Provider Manual;
2. Access to enduring reference materials available through health plan representatives and the Molina Healthcare website;
3. Integration of cultural competency concepts into provider communications; and
4. Continuing Medical Education.

Integrated Quality Improvement – Ensuring Access

Molina Healthcare ensures member access to language services such as written translation and access to programs and services that are congruent with cultural norms and provide quality care.

Members may also request written member materials in Spanish and alternative formats. Such congruency with member populations leads to better communication, understanding and member satisfaction.

Key member information, including Appeals and Grievance forms, are also available in threshold languages on the Molina member website.

Program and Policy Review Guidelines

Molina Healthcare conducts assessments at regular intervals of the following information in order to ensure its programs are most effectively meeting the needs of its members and providers:

- Annual review of membership demographics (preferred language, ethnicity, race)
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
- Network Assessment
- Applicable national demographics and trends derived from publicly available sources
- Health status measures such as those measured by HEDIS as available
- Comparison with selected measures such as those in Healthy People 2010

Section 16. HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

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

Provider/Practitioner Responsibilities

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

Applicable Laws

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

1. Federal Laws and Regulations
    - HIPAA
2. Applicable State Laws and Regulations

Providers/practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers/practitioners should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a provider/practitioner may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) without the consent or

authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the provider/practitioner's own TPO activities, but also for the TPO of another covered entity[2]. Disclosure of PHI by one covered entity to another covered entity, or healthcare provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[3]."

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

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

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

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

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

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

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

1. ***Notice of Privacy Practices***

   Providers/practitioners that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The provider/practitioner should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. ***Requests for Restrictions on Uses and Disclosures of PHI***

   Patients may request that a healthcare provider/practitioner restrict its uses and disclosures of PHI. The provider/practitioner is not required to agree to any such request for restrictions.

3. ***Requests for Confidential Communications***

   Patients may request that a healthcare provider/practitioner communicate PHI by alternative means or at alternative locations. Providers/practitioners must accommodate reasonable requests by the patient.

4. ***Requests for Patient Access to PHI***

   Patients have a right to access their own PHI within a provider/practitioner's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a provider/practitioner includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.

5. ***Request to Amend PHI***

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

6. ***Request Accounting of PHI Disclosures***

   Patients may request an accounting of disclosures of PHI made by the provider/practitioner during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

HIPAA Security

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

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

HIPAA Transactions and Code Sets

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

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

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at http://www.molinahealthcare.com for additional information. Click on the area titled "For Health Care Professionals", click the tab titled "HIPAA" and then click on the tab titled "Transactions Readiness" or "HIPAA Code Sets."

National Provider Identifier

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

Additional Requirements for Delegated Providers/Practitioners

Providers/practitioners that are delegated for claims and utilization management activities are the "business associates" of Molina Healthcare. Under HIPAA, Molina Healthcare must obtain contractual

assurances from all business associates that they will safeguard member PHI. Delegated providers/practitioners must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF TEXAS, INC.

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

Molina Healthcare of Texas, Inc. ("**Molina Healthcare**", "**Molina**", "**we**" or "**our**") uses and shares protected health information about You to provide Your health benefits. We use and share Your information to carry out treatment, payment and health care operations. We also use and share Your information for other reasons as allowed and required by law. We have the duty to keep Your health information private and to follow the terms of this Notice. The effective date of this Notice is January 1, 2014.

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

Why does Molina Healthcare use or share Your PHI?
We use or share Your PHI to provide You with healthcare benefits. Your PHI is used or shared for treatment, payment, and health care operations.

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

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

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

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

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

We will share Your PHI with other companies ("**business associates**") that perform different kinds of activities for our health plan. We may also use Your PHI to give You reminders about Your appointments. We may use Your PHI to give You information about other treatment, or other health-related benefits and services.

When can Molina Healthcare use or share Your PHI without getting written authorization (approval) from You?
The law allows or requires Molina Healthcare to use and share Your PHI for several other purposes. These include the following:

Required by Law
We will use or share information about You as required by law. We will share Your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

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

Health Care Oversight
Your PHI may be used or shared with government agencies. They may need Your PHI for audits.

Research
Your PHI may be used or shared for research in certain cases.

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

Health and Safety
Your PHI may be shared to prevent a serious threat to public health or safety.

Government Functions
Your PHI may be shared with the government for special functions. An example would be to protect the President.

Victims of Abuse, Neglect or Domestic Violence
Your PHI may be shared with legal authorities if we believe that a person is a victim of abuse or neglect.

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

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

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI?
Molina Healthcare needs Your written approval to use or share Your PHI for a purpose other than those listed in this Notice. Molina needs Your authorization before we disclose Your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that You have given us. Your cancellation will not apply to actions already taken by us because of the approval You already gave us.

What are Your health information rights?
You have the right to:

- **Request Restrictions on PHI Uses or Disclosures. (Sharing of Your PHI)**
  You may ask us not to share Your PHI to carry out treatment, payment or health care operations. You may ask us not to share Your PHI with family, friends or other persons You name who are involved in Your health care. However, we are not required to agree to Your request. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Request Confidential Communications of PHI**
  You may ask Molina Healthcare to give You Your PHI in a certain way or at a certain place to help keep it private. We will follow reasonable requests if You tell us how sharing all or a part of that PHI could put Your life at risk. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Review and Copy Your PHI**
  You have a right to review and get a copy of Your PHI held by us. This may include records used in making coverage, claims and other decisions as a Molina Healthcare Member. You will need to make Your request in writing. You may use Molina's form to make Your request. We may charge You a reasonable fee for copying and mailing the records. In certain cases we may deny the request.
  Important Note: We do not have complete copies of Your medical records. If you want to look at, get a copy of, or change Your medical records, please contact Your doctor or clinic.

- **Amend Your PHI**
  You may ask that we amend (change) Your PHI. This involves only those records kept by us about You as a Member. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request. You may file a letter disagreeing with us if we deny the request.

- **Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**
  You may ask that we give You a list of certain parties that we shared Your PHI with during the six years prior to the date of Your request. The list will not include PHI shared as follows:

  - for treatment, payment or health care operations;
  - to persons about their own PHI;
  - shared with Your authorization;
  - incident to a use or disclosure otherwise permitted or required under applicable law;
  - PHI released in the interest of national security or for intelligence purposes; or
  - as part of a limited data set in accordance with applicable law.

We will charge a reasonable fee for each list if You ask for this list more than once in a 12- month period. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.
You may make any of the requests listed above, or may get a paper copy of this Notice. Please call our Customer Support Center at 1-888-560-2025.

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

You may complain to us at:

Customer Support Center
15115 Park Row Suite 160

Houston, TX 77084
1-888-560-2025

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

Office for Civil Rights
U.S. Department of Health & Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

What are the duties of Molina Healthcare?
Molina Healthcare is required to:

- Keep Your PHI private;
- Give You written information such as this on our duties and privacy practices about Your PHI;
- Provide you with a notice in the event of any breach of Your unsecured PHI;
- Not use or disclose Your genetic information for underwriting purposes;
- Follow the terms of this Notice.

This Notice is Subject to Change

Molina Healthcare reserves the right to change its information practices and terms of this Notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, Molina will post the revised Notice on our web site and send the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to our members then covered by Molina.

Contact Information

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

Customer Support Center
15115 Park Row Suite 160
Houston, TX 77084
Phone: 1-888-560-2025

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:			**Member ID #:**
Member Address:			**Date of Birth:**
City:	**State:**	**Zip:**	**Phone #:**

I authorize the use or disclosure of my protected health information (PHI) as stated below.

1. Name and address of Molina Healthcare (Molina) entity authorized to use or disclose the PHI:

2. Name and address of person or organization authorized to receive or use the PHI:

3. Description of the PHI that may be used and/or disclosed*:

I know that this may include PHI related to:

- Sexually transmitted diseases;
- HIV/AIDS;
- Other communicable diseases;
- Behavioral or mental health diseases; and
- Referral and/or treatment for alcohol and drug abuse (as permitted under 42 CFR Part 2)

4. The PHI will be used and/or disclosed for the following purpose(s):

_____

_____

_____

5. I know that:

   a. This authorization is voluntary.
   b. I do not have to sign this form. I can refuse to.
   c. My refusal to sign will not affect any of the following:

      - My eligibility for benefits or enrollment;
      - Payment for services; or
      - My ability to be treated

   d. I have a right to get a copy of this form. I must ask for a copy.
   e. I may revoke this authorization at any time. To do so I have to let Molina know in writing. Such revocation will not apply to actions that Molina has taken in reliance on this authorization.
   f. The PHI I authorize a person or entity to get may no longer be protected by federal law and regulations.

6. This authorization will expire on this date or event* :

   _____

   **If not stated above, this authorization will expire 12 months from the date below*.

_____ _____

Signature of Member or Member's Personal Representative | Date

_____ _____

Personal Representative's Name, if applicable (please print):

_____

Relationship to Member: ☐Parent ☐Legal Guardian* ☐Holder of Power of Attorney *

☐Other Please Describe:

_____

*** Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney for Healthcare Decisions**

A copy of this signed form will be given to the Member, if Molina sought it.

Section 17. Glossary of Terms

Affordable Care Act: the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, together with the federal regulations implementing this law and binding regulatory guidance issued by federal regulators.

Annual Out-of-Pocket Maximum:

For Individuals - is the total amount of Cost Sharing an individual member will have to pay for Covered Services in a calendar year. The Cost Sharing and individual Annual Out-of-Pocket Maximum amounts applicable to members are specified in the Molina Healthcare Benefits and Coverage Guide. Cost Sharing includes payments members make towards any Deductibles, Copayments or Coinsurance. Once a member's total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, Molina will pay 100% of the charges for Covered Services for the remainder of the calendar year. Amounts that members pay for services that are not Covered Services under this Certificate will not count towards the individual Annual Out-of-Pocket Maximum.

For Family (2 or more Members) – is the total amount of Cost Sharing that at least two or more members of a family will have to pay for Covered Services in a calendar year. The Cost Sharing and family Annual Out-of-Pocket Maximum amounts applicable are specified in the Molina Healthcare Benefits and Coverage Guide. Cost Sharing includes payments members make towards any Deductibles, Copayments or Coinsurance. Once the total Cost Sharing made by at least two or more members of a family reaches the specified Annual Out-of-Pocket Maximum amount, Molina will pay 100% of the charges for Covered Services for all enrolled family members for the remainder of the calendar year. Amounts that members pay for services that are not Covered Services under this Certificate will not count towards the family Annual Out-of-Pocket Maximum.

Authorization or Authorized: a decision to approve specialty or other Medically Necessary care for a member by the member's PCP, medical group or Molina Healthcare. An Authorization is usually called an "approval."

Benefits and Coverage: (also referred to as "**Covered Services**") the healthcare services that members are entitled to receive from Molina Healthcare under this Agreement.

Coinsurance: a percentage of the charges for Covered Services members must pay when they receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina Healthcare has negotiated with the Participating Provider. Coinsurances are listed in the Molina Healthcare Benefits and Coverage Guide. Some Covered Services do not have Coinsurance and may apply a Deductible or Copayment.

Copayment: a specific dollar amount members must pay when they receive Covered Services. Copayments are listed in the Molina Healthcare Benefits and Coverage Guide. Some Covered Services do not have a Copayment, and may apply a Deductible or Coinsurance.

Cost Sharing: the Deductible, Copayment, or Coinsurance that members must pay for Covered Services under this Agreement. The Cost Sharing amount members will be required to pay for each type of Covered Service is listed in the Molina Healthcare Benefits and Coverage Guide.

Deductible: is any amount members must pay in a calendar year for certain Covered Services received before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that members pay towards their Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. The amount of the Deductible, if any, is listed in the Molina Healthcare Benefits and Coverage Guide. Depending on the member's coverage, the Deductible amount may be $0. There are two kinds of Deductibles that apply to Covered Services.

A "**Medical Deductible**" applies only to Outpatient Hospital or Facility and Inpatient Hospital or Facility services. It does not apply to outpatient professional services such as doctor office visits.

A "**Prescription Drug Deductible"** applies only to Formulary Non-Preferred Brand Name drugs and Specialty Drugs as described in the Prescription Drug Coverage benefit in the EOC.

When Molina Healthcare covers services at "no charge" subject to the Deductible and members have not met their Deductible amount, the member must pay the charges for the services. When preventive services covered by Molina are included in the Essential Health Benefits, members will not pay any Deductible or other Cost Sharing towards those preventive services.

Dependent: a member who meets the eligibility requirements as a Dependent, as described in the Evidence of Coverage.

Drug Formulary: is Molina Healthcare's list of approved drugs.

Durable Medical Equipment: is medical equipment that serves a repeated medical purpose and is intended for repeated use. It is generally not useful to members in the absence of illness or injury and does not include accessories primarily for member comfort or convenience.

Emergency or **Emergency Medical Condition**: the sudden onset of a medical, psychiatric or substance abuse condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services: mean health care services needed to evaluate, stabilize or treat an Emergency Medical Condition.

Essential Health Benefits or "**EHB**": a standardized set of essential health benefits that are required to be offered by Molina Healthcare to members and their dependents, as determined by the Affordable Care Act. Essential Health Benefits covers at least the following 10 categories of benefits:

- Ambulatory patient care
- Emergency services

- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental* and vision care for Members under the age of 19

*Pediatric dental services may be separately provided through a stand-alone dental plan that is certified by the Marketplace.

Experimental or Investigational: any medical service including procedures, medications, facilities, and devices that Molina Healthcare has determined have not been demonstrated as safe or effective compared with conventional medical services.

FDA: the United States Food and Drug Administration.

Health Care Facility: an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

Marketplace: a governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and helps residents of the State of Texas buy qualified health plan coverage from insurance companies or health plans. The Marketplace may be run as a state-based marketplace, a federally-facilitated marketplace or a partnership marketplace. For the purposes of this document, the term refers to the Marketplace operating in the State of Texas, however, it may be organized and run.

Medically Necessary or **Medical Necessity:** health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

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

Member: an individual who is eligible and enrolled under the Agreement, and for whom we have received applicable Premiums. The term includes a Subscriber and a Dependent.

Molina Healthcare of Texas, Inc. (Molina Healthcare or Molina): the corporation licensed by Texas as a Health Maintenance Organization, and contracted with the Marketplace.

Non-Participating Provider: refers to those physicians, hospitals, and other providers that have not entered into contracts to provide Covered Services to Molina Marketplace members.

Other Practitioner: refers to Participating Providers who provide Covered Services to Members within the scope of their license, but are not Primary Care Physicians or Specialist Physicians.

Participating Provider: refers to those providers, including hospitals and physicians that have entered into contracts to provide Covered Services to Members through this product offered and sold through the Marketplace.

Premiums: mean periodic membership charges paid by or on behalf of each Member. Premiums are in addition to Cost Sharing.

Primary Care Doctor (also Primary **Care Physician**): the doctor who takes care of a member's health care needs. A Primary Care Doctor may be one of the following types of doctors:

- Family or general practice doctors who usually can see the whole family.
- Internal medicine doctors, who usually only see adults and children 14 years or older.
- Pediatricians, who see children from newborn to age 18 or 21.
- Obstetricians and gynecologists (OB/GYNs).

Primary Care Provider or **"PCP":**

- a Primary Care Doctor, or
- an individual practice association (IPA) or group of licensed doctors which provides primary care services through the Primary Care Doctor.

Referral: the process by which the Member's Primary Care Doctor directs the Member to seek and obtain Covered Services from other providers.

Service Area: the geographic area in Texas where Molina Healthcare has been authorized by the Texas Department of Insurance to market individual products sold through the Marketplace, enroll Members obtaining coverage through the Marketplace and provide benefits through approved individual health plans sold through the Marketplace.

Specialist Physician: any licensed, board-certified, or board-eligible physician who practices a specialty and who has entered into a contract to deliver Covered Services to Members.

Spouse: the Subscriber's legal husband or wife.

Subscriber: an individual who is a resident of Texas, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina Healthcare as the Subscriber, and has maintained membership with Molina Healthcare.

Urgent Care Services: those health care services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.