Provider Manual

Molina Healthcare of Washington, Inc.

(Molina Healthcare or Molina)

2018 Molina Medicaid

Effective 1/1/2018

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ADDRESSES AND PHONE NUMBERS

Please register on the Molina Healthcare WebPortal at https://eportal.molinahealthcare.com/Provider/Registration. By registering you can access online member eligibility, claims status and claims submission. You can also submit authorization requests through the WebPortal or Clear Coverage online and in some cases receive auto approval for services using our rules based submission process. Our secure Provider Portal is also available through OneHealthPort (OHP) single sign on at www.onehealthport.com/.

Member and Provider Contact Center

The Contact Center handles all telephone and written inquiries regarding claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and Member complaints. Contact Center Representatives are available to assist Members and Providers 7:30am to 6:30pm Monday through Friday, excluding State holidays.

Contact Center
Address: Molina Healthcare of Washington, Inc. PO Box 4004 Bothell, WA 98041-4004
Member Phone: (800) 869-7165 Provider Phone: (855) 322-4082
TTY: 711

Claims

Molina requires Providers to submit Claims electronically through a clearinghouse or Molina's secure Provider Portal. Claims submitted electronically must use EDI payor ID number – 38336. To verify the status of your claim, please use the Provider Portal or call our Provider Contact Center Representatives at the numbers listed below. Contact Center Representatives are available 7:30am to 6:30pm Monday through Friday, excluding State holidays.

Claims
EDI Payer ID: 38336
Phone: (855) 322-4082
Fax: (800) 816-3778

Claims Recovery Department

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

Claims Recovery Disputes and Refunds
Refunds Address: Molina Healthcare of Washington, Inc. PO Box 30717 Los Angeles, CA 90030-0717 **Disputes** Address: Molina Healthcare of Washington, Inc. PO Box 2470 Spokane, WA 99210-2470
Phone: (866) 642-8999
Fax: (888) 396-1520

Contracting Department

The Contacting department should be contacted if you are interested in contracting with Molina Healthcare or checking on the status of your contract. Contracting is available 8:00am to 5:00pm Monday through Friday, excluding State holidays.

Contracting Department
Address: Molina Healthcare of Washington, Inc. PO Box 4004 Bothell, WA 98041-4004
Phone: (855) 322-4082 ex.142630
Fax: (877) 814-0542
e-mail: MHWProviderContracting@MolinaHealthCare.Com

Credentialing Department

The Credentialing Department verifies all information on the Washington Practitioner Application prior to contracting and re-verifies this information every three years. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina Healthcare network. The Credentialing Department also performs office and medical record reviews.

Credentialing
Address: Molina Healthcare of Washington, Inc. PO Box 2470 Spokane, WA 99210-2470
Phone: (888) 562-5442
Fax: (800) 457-5213

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, 7 days a week to assess symptoms and help make good health care decisions.

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

Healthcare Services (Authorization Department)

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

Healthcare Services Authorizations
Address: Molina Healthcare of Washington, Inc. PO Box 4004 Bothell, WA 98041-4004
Phone: (855) 322-4082
Medical/Behavioral Services Fax: (800) 767-7188
Inpatient Census Fax: (800) 413-3806
NICU Fax: (877) 731-7220
Transplant Fax: (877) 813-1206
Advanced Imaging Fax: (877) 731-7218

EXCEPTION: *If the Member's PCP belongs to a delegated medical group/Independent Practice Association (IPA), listed in Section 14, the Provider should contact that medical group/IPA for Authorization guidance.*

Health Education and 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 program and services.

Health Education & Health Management	
Address:	Molina Healthcare of Washington, Inc. PO Box 2470 Spokane, WA 99210-2470
Phone:	(800) 423-9899, Ext. 141453
Fax:	(800) 461-3234

Pharmacy Department

Molina Healthcare's drug formulary requires prior Authorization for certain medications. The Pharmacy Department can answer questions regarding the formulary and/or drug prior Authorization requests. The Molina Healthcare formulary is available at www.MolinaHealthcare.com.

Pharmacy Authorizations	
Phone:	(855) 322-4082
Fax:	(800) 869-7791

Caremark Pharmaceuticals

When a Molina Healthcare Member needs an injectable medication, the prescription can be submitted to Molina Healthcare by fax. For a current listing of available injectable medications, please check the web address below or use the link at www.MolinaHealthcare.com.

Caremark	
Fax:	(800) 869-7791
Online:	https://www.caremark.com

Provider Resolution Department

The Provider Resolution Department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, Provider appeals and disputes and training. Provider Resolution Representatives are available to assist you Monday through Friday 8:00am to 5:00pm, excluding State holidays.

Provider Resolution Department
Address: Molina Healthcare of Washington, Inc. PO Box 4004 Bothell, WA 98041-4004
Phone: (855) 322-4082
Fax: (877) 814-0342
e-mail: MHWProviderServicesInternalRep@Molinahealthcare.com

Vision Service Plan (VSP)

Molina Healthcare is contracted with VSP to provide routine vision services for our Members. Members who are eligible may directly access a VSP network Provider.

VSP
Phone: (800) 615-1883

EXCEPTION: *If the Member's PCP belongs to a delegated medical group/IPA, listed in Section 14, the Provider should contact that medical group/IPA for Authorization guidance.*

ENROLLMENT, ELIGIBILITY AND DISENROLLMENT

Enrollment in Washington Apple Health, Apple Health Integrated Managed Care (IMC) Medicaid Programs and Behavioral Health Services Only (BHSO)

Molina Members are enrolled in a managed care health plan after the Health Care Authority (HCA) determines a Member is eligible for medical assistance through Apple Health Medicaid. Members may enroll with Molina if they reside within Molina's Service Area (please see http://www.molinahealthcare.com/providers/wa/medicaid/contacts/Pages/service_area.aspx for Molina's current Service Area). To enroll with Molina, the Member, his/her representative or his/her responsible parent/ guardian must complete and application online at www.wahealthplanfinder.org or call the Customer Support Center at (855)WAFINDER (855-923-4633) or (855) 627-9604 (TTY).

HCA will enroll all eligible Members with the health plan of their choice. If the Member does not choose a plan, HCA will assign the Member and his/her family to a plan that services the area where the Member resides. The following groups of Members, eligible for medical assistance, must enroll in a managed care plan:

- Members receiving Medicaid under the Social Security Act (SSA) provisions for coverage of families receiving Temporary Assistance for Needy Families (TANF)
- Members who are not eligible for cash assistance but remain eligible for Medicaid
- Children from birth through 18 years of age eligible for Medicaid under expanded pediatric coverage provisions of the SSA ("H" Children)
- Pregnant women eligible for Medicaid under expanded maternity coverage provisions of the SSA ("S" Women)
- Members who meet the SSA definition of blind or meet the SSA definition of persons with disabilities and are not eligible for Medicare

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

Earlier Enrollment allows clients to be enrolled into a plan the same month they become eligible for Medicaid, as opposed to waiting until the next month to be enrolled. Earlier enrollment applies to clients who are new to Medicaid or who have had a break in eligibility and are recertified for Medicaid services. The client will be retro effective to the first of the month they were determined eligible for Medicaid. The current month enrollment is intended to allow the client continuous enrollment in managed care from the date of enrollment. When a member changes from one health plan to the next the change will always be effective the first of the following month.

HCA notifies eligible Members of their rights and responsibilities as plan Members and sends them a booklet at the time of initial eligibility determination. Before the end of each month, HCA sends Molina a list of assigned Members for the following month. Molina sends each new Member a Molina Member ID card and welcome letter within 15 days of initial enrollment with Molina. The letter includes important information for the new member such as how to access their online handbook and how to contact Molina.

Inpatient at time of Enrollment

Regardless of what program or health plan the Member is enrolled in at discharge (Medicaid Fee-for-Service (FFS) or an Apple Health plan), the program or plan the enrollee 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 enrollee is no longer confined to an acute care hospital or Skilled Nursing Facility or eligibility to receive Medicaid services ends.

For newborns born while their mother is hospitalized, the party responsible for the payment of covered services for the mother's hospitalization shall be responsible for payment of all covered inpatient facility and professional services provided to the newborn from the date of admission until the date the newborn is no longer confined to an acute care hospital, unless their mother is receiving FFS A newborn whose mother is receiving services when the baby is born will be enrolled on an Apple Health plan according to Earlier Enrollment rules.

When a newborn is placed in foster care, the newborns will remain enrolled with the Apple Health plan for the month of birth. The newborn will be enrolled with the Apple Health Foster Care (AHFC) program effective the first of the month following placement of the newborn.
Enrollment Exemption: In some cases, a Member may request exemption from enrollment in a plan. Each request for exemption is reviewed by HCA pursuant to Washington Administration Code (WAC) 182-538-130.

Eligibility Verification

Eligibility is determined on a monthly basis. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

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

- Molina Healthcare Member ID card
- Monthly PCP eligibility listing located on the Molina Provider WebPortal
- Molina Healthcare Member Services at (800) 869-7165
- Molina Healthcare WebPortal at www.MolinaHealthcare.com / Provider Self Services
- ProviderOne website

Providers may also use a Medical Eligibility Verification (MEV) service. Molina sends eligibility information including PCP assignment to Provider Advantage and Change Health. Some MEV services provide access to online Medicaid Member eligibility data and can be purchased through approved HCA vendors. MEV services provide eligibility information for billing purposes, such as:

- Eligibility status
- Plan enrollment and plan name
- Medicare enrollment
- Availability of other insurance
- Program restriction information

HCA updates the MEV vendor list as new vendors develop MEV services. For more information and a current list of HCA vendors, please call (800) 562-3022.

Providers can also access eligibility information for Members free of charge using the ProviderOne online service. In order to access eligibility on the website you must register online and complete an application. Online enrollment information can be found at: http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-provider

Eligibility Listing

Eligibility reports are available for viewing at any time on the secure Provider WebPortal. The report includes information regarding members assigned to the PCP's at that clinic location. The eligibility reports are refreshed hourly. You can also verify a Members PCP assignment by looking up the individual member in the WebPortal. You may also call Molina's Member Services Department at (800) 869-7165 to verify eligibility.

Identification Card

An individual determined to be eligible for medical assistance is issued a ProviderOne Services Card by HCA. It is issued once upon enrollment. Providers must use the ProviderOne Client ID on the card to verify eligibility either through the ProviderOne website at https://www.waproviderone.org/ or via a Services Card swipe card reader. Providers must check Member eligibility at each visit and should make note of the following information:

- Eligibility dates (be sure to check for the current month and year)
- The ProviderOne Client ID number
- Other specific information (e.g. Medicare, Apple Health, IMC, BHSO, etc.)

Medical assistance program coverage is not transferable**.** If you suspect a Member has presented a ProviderOne (Services Card) belonging to someone else, you should request to see a photo ID or another form of identification. To report suspected Member fraud, call the Medicaid Fraud Hotline at (800) 562-6906. **Do not accept a Services Card that appears to have been altered.**

All Members enrolled with Molina receive an identification card from Molina in addition to the Services Card. Molina sends an identification card for each family Member covered under the plan. The Molina ID card has the name and phone number of the Member's assigned PCP.

Members are reminded to carry both ID cards (Molina ID card and Services Card) with them when requesting medical or pharmacy services. **It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment, prior to rendering services.** Unless an emergency condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Please see section 16, Sample ID cards to review the ID cards issued to members assigned to Molina.

Voluntary Disenrollment

Members may request termination of enrollment from the health plan by submitting a written request to HCA or by calling the toll-free enrollment number at (800) 562-3022. Requests for termination of enrollment may be made in order for the Member to enroll with another health plan, or disenroll from managed care completely. Members whose enrollment is terminated will be prospectively disenrolled. HCA notifies Molina of all terminations. Neither the Provider nor Molina may request voluntary disenrollment on behalf of a Member.

Involuntary Disenrollment

When a Member becomes ineligible for enrollment due to a change in eligibility status, or if the Member has comparable coverage, HCA will disenroll the Member and notify Molina.

Molina may request the involuntary termination of a Member for cause by sending a written notice to HCA. HCA will approve/disapprove the request for termination within thirty (30) working days of receipt of request. Molina must continue to provide medical services to the Member until they are disenrolled. HCA will not disenroll a Member based solely on an adverse change in the Member's health status or the cost of his/her health care needs. HCA may involuntarily terminate the Member's enrollment when Molina has substantiated all of the following in writing:

- The Member's behavior is inconsistent with Molina Healthcare's rules and regulations, such as:
- Intentional misconduct
- Purposely putting the safety of members, Molina Healthcare staff or providers at risk
- Refusing to follow procedures or treatment recommended by provider and determined by Molina Medical Director to be essential to member's health and safety
- Molina Healthcare has provided a clinically appropriate evaluation to determine whether there is a treatable condition contributing to the Member's behavior and such evaluation either finds no treatable condition to be contributing or, after evaluation and treatment, the Member's behavior continues to prevent the Provider from safely or prudently providing medical care to the Member.
- The Member received written notice from Molina of its intent to request disenrollment, unless the requirement for notification has been waived by HCA because the Member's conduct presents the threat of imminent harm to others. Molina's notice to the Member must include the following:
    a) The Member's right to use Molina's appeal process to review the request to terminate the enrollment
    b) The Member's right to use the HCA hearing process

A Member whose enrollment is terminated at any time during the month is entitled to receive covered services at Molina's expense through the end of that month. If the Member is inpatient at an acute care hospital at the time of disenrollment, and the Member was enrolled with Molina on the date of admission, Molina and its contracted medical groups/IPAs shall be responsible for all inpatient facility and professional services from the date of admission through the date of discharge from the hospital unless eligibility to receive Medicaid services ends.

Supplemental Security Income (SSI)

SSI is a federal income supplement program funded by general tax revenues. It is designed to help aged, blind and disabled people who have little or no income and provides cash to meet basic needs for food, clothing and shelter. Members who are eligible for SSI receive medical care through Medicaid FFS and Apple Health Blind Disabled (AHBD) (only non-dual blind and disabled Members), but are not eligible for Apple Health Family (AHFAM), Apple Health with Premium (AHPREM) or Apple Health Adult (AHA).

When identified by case managers, Molina assists Members in pursuing SSI approvals. Until SSI is approved for the Member, Molina and its contracted medical groups/IPAs are financially responsible for all costs associated with medical management of the Member.

AHFAM, AHPREM and AHA adults who are determined to be SSI eligible due to being blind or disabled will prospectively change eligibility categories to AHBD (blind disabled) and will continue coverage through their designated health plan. Adults determined to be SSI eligible due to being aged will be dis-enrolled prospectively and HCA will not recoup any premiums from Molina. Molina and its contracted medical groups/IPAs will be responsible for providing services until the effective date of disenrollment.

If terminated, disenrollment processed on or before the HCA cut-off date, will occur the first day of the month following the month in which the termination is processed by HCA. If the termination is processed after the HCA cut-off date, disenrollment will occur the first day of the second month following the month in which the termination is processed by HCA.

Maternity and Newborn Coverage

Obstetrical (OB) care is covered for all Apple Health and IMC members. An Apple Health and IMC newborn is automatically covered through the end of the month in which the 21st day of life falls. Continued coverage is contingent upon the mother reporting the newborn to their Community Service Office (CSO) or logging into her Healthplanfinder account. If eligible, the newborn will receive a Services Card. If the baby is not reported, medical coverage ends at the end of the month in which the 21st day of life falls, unless the baby is in the hospital in which case coverage ends at discharge. If the mother changes health plans within the initial three months of life, the newborn's coverage will follow the mother's.

PCP Assignment

Molina Members have the right to choose their own PCP. If the Member does not choose a PCP, Molina will assign one to the Member based on reasonable proximity to the Member's home and prior assignments. Newborns are assigned to the mother's PCP through the first full month of coverage following discharge from the hospital. Newborns enrolled in a Molina Healthcare plan may receive services from any Molina Healthcare contracted PCP during the first sixty days after birth.

If a Member would like to know about a PCP's medical training, board certification, or other qualifications, the Member can call Member Services. This includes PCPs, specialists, hospitals and other Providers.

PCP Change

A Member can change their PCP at any time with the change being effective no later than the beginning of the month following the Member's request for the change. If the Member is receiving inpatient hospital services at the time of the request, the change will be effective the first of the month following discharge from the hospital. The guidelines are as follows:

1. If a Member calls to make a PCP change prior to the 15th of the month, the Member will be allowed to retroactively change their PCP to be effective the first of the current month, provided The Member is new to Molina that month.
2. If a Member calls to change the PCP and has been with Molina for over 15 days, the PCP change will be made prospectively to the first of the next month.
3. If the Member was assigned to the incorrect PCP due to Molina's error, the Member can retroactively change the PCP, effective the first of the current month.

There are two instances in which a PCP can request a change on behalf of the Member and the change can be made retroactive to the first of the month. They are:

1. The Member lives outside their PCP's service area.
2. The Member is assigned to a closed panel PCP because the Member chose the PCP on their Medicaid enrollment form.

Newborn PCP Assignment

- Newborns will be assigned to the mother's PCP through the first full month of coverage following discharge from the hospital.
- The mother may select a different PCP for her newborn effective the first full calendar month after discharge from the hospital by notifying Member Services.
- While assigned to the mother's PCP, the newborn may see the chosen PCP as long as the PCP is participating with Molina or one of the capitated medical groups/IPAs.
- Molina and its capitated medical groups/IPAs will be responsible for paying the PCP services provided during this time period.

Financial Responsibility and Medical Management Authority

If the mother's PCP is part of a contracted medical group/IPA, that group/IPA will be financially responsible for covered services and has the authority to medically manage the newborn until the end of the first full calendar month of coverage after discharge from the hospital. If a hospitalized newborn loses eligibility, the contracted medical group/IPA or Molina is responsible for coverage until the newborn is discharged from the acute care facility. A transfer from one acute care facility to another is not considered
a discharge.

PCP Dismissal

A PCP may dismiss a Member from his/her practice based on the following reasons. The issues must be documented by the PCP:

- Repeated "No-Shows" for scheduled appointments
- Inappropriate behavior

This Section does not apply if the member's behavior is resulting from his or her special needs, except when his or her continued assignment to the PCP seriously impairs the PCP's ability to furnish services to either the individual member or other members. The Member must receive written notification from the PCP explaining in detail the reasons for dismissal from the practice. The provider may use the approved "PCP Member Dismissal Letter Template" located on the Molina website at www.Molinahealthcare.com under the forms section. The PCP may use their own dismissal letter after approval by Molina. A copy of the dismissal letter should be faxed to Member Services at (800) 816-3778. Molina will contact the Member and assist in selecting a new PCP. The current PCP must provide emergency care to the Member for thirty (30) days during this transition period.

PCP Panel Closure – "New Members"

If a PCP determines that they are unable to accommodate "new" Members he or she can elect to close his or her panel. Molina must receive 30 days advance notice from the provider. Once the panel is closed, no new Members will be assigned to the PCP with the following exceptions:

- Family Members of existing Members will continue to be assigned;
- Members who were previously assigned to the PCP prior to a loss of eligibility will continue to be "reconnected" to the PCP.
- Members not currently assigned to you, but you have provided services 2 or more times in a 12 month period. The system will be automatically re-assign the member to you based on claims data.

Written correspondence is required and must include the reason and the effective date of the closure. If the panel will not be closed indefinitely, correspondence should also include the re-open date. If a reopen date for the panel is not known, a letter will need to be submitted when the office is ready to reopen the panel to new patients.

PCP Panel Closure – "New & Previously Assigned Members"

In the event a PCP determines they are unable to serve not only New Members, but also Members who have been previously assigned, the PCP must close his or her panel by providing immediate written notice to Molina.

Molina will identify those Members for potential re-assignment to an alternate PCP using the following objective criteria:

- Members were assigned to the PCP within the last 1- 6 months
- Member has never been seen by the PCP and does not have a scheduled appointment
- Member is not a Family Member of a member being actively seen by the PCP

The Member must receive written notification from the PCP explaining in detail the reasons for dismissal from the practice. The provider may use the approved "PCP Member Dismissal Letter Template" located on the Molina website at www.Molinahealthcare.com under the forms section. The PCP may use their own dismissal letter after approval by Molina. A copy of the dismissal letter should be faxed to Member Services at (800) 816-3778. Molina will contact the Member and assist in selecting a new PCP. The current PCP must provide emergency care to the Member for thirty (30) days during this transition period.

MEMBER RIGHTS AND RESPONSIBILITIES

This section explains the rights and responsibilities of Molina Members. Providers and their office staff who contract with Molina are encouraged to be familiar with these rights and responsibilities and are expected to abide by them. Also included in this section is information about providing interpreter services, women's health care services and enrollee self-determination regarding Advance Directives, natural death act and anatomical gifts.

Below are the Member Rights and Responsibilities:

Molina Member Rights & Responsibilities Statement

You have the right to:

- Get the facts about Molina, our services and Providers who contract with us to provide services
- Have privacy and be treated with respect and dignity
- Help make decisions about your health care. You may refuse treatment.
- Ask for and receive a copy of your medical records or ask for us to amend or correct them
- Openly talk about your treatment options in a way you understand them. It does not matter what the cost or benefit coverage.
- Voice any Complaints (grievance) or Appeals about Molina or the care you were given
- Use your Member rights without fear of negative results
- Receive the Members' rights and responsibilities at least yearly
- Suggest changes to this policy

You have the responsibility to:

- Give, if you can, all facts that Molina and the Providers need to care for you
- Know your health problems and take part in making agreed upon treatment goals as much as possible
- Follow the plan and instructions for care you agree to with your Provider
- Treat your Providers with respect
- Keep appointments and be on time. If you are going to be late or cannot keep an appointment, call your Provider.
- Show your Molina ID card and your Services Card for all services. Also show the ID card for any other insurance you may have including Medicare.

Special Provisions for American Indians and Alaska Natives

If an American Indian/Alaska Native Enrollee indicates that he or she wishes to have an IHCP as his or her PCP, Molina must treat the IHCP as an in network PCP for the Enrollee regardless of whether or not the IHCP has entered into a subcontract with Molina.

Molina must honor the referral of an out-of-network IHCP to refer an AI/AN Enrollee to a network provider. (42 C.F.R. § 438.14(b)(6)).

In accord with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Molina is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating IHCPs for contracted services provided to American Indian and Alaska Native Enrollees at a rate equal to the rate negotiated between the Contractor and the IHCP. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an IHCP.

For Indian Health Care Providers (IHCPs) that are FQHCs, when the amount the IHCP receives from the Contractor for services to an Indian Enrollee of the Contractor's plan is less than the total amount the IHCP is entitled receive (including any supplemental payment under Section 1902(bb)(5) of the Social Security Act, the state must make a supplemental payment to the IHCP to make up the difference between the amount Molina pays and the amount the IHCP is entitled to receive as an FQHC, whether or not the IHCP has a contract with Molina. For IHCPs that are not FQHCs, when the amount the IHCP receives from Molina is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, the state must make a supplemental payment to the IHCP to make up the difference between the amount Molina pays and the amount the IHCP would have received under FFS or the applicable encounter rate, whether or not the IHCP has a contract with Molina.

Interpreter Services

All eligible Members who are Limited English Proficient (LEP) are entitled to receive interpreter services for all types of appointments and for assisting in filing a complaint or appeal through the Health Care Authority (HCA) at no cost to the Member. An LEP individual may have a limited ability or inability to read, speak or write English well enough to understand and communicate effectively. Providers are responsible for assuring interpreter services are made available.
If you would like to arrange for interpreter services you must use a broker that is contacted with HCA. If you would like to obtain a current list of contracted brokers by county, please go to:
http://www.hca.wa.gov/billers-providers/programs-and-services/interpreter-services
E-mail: interpretersvcs@hca.wa.gov

Women's Healthcare Services

Under Washington State Law, women must be allowed to have direct access to women's health care Providers who contract with Molina without a referral or prior authorization from PCPs.

Generally, women's health care Providers are not considered PCPs. Referrals from PCPs for women's health care services are **not** required, but the services must be obtained from a Molina network Provider. A Molina Member may seek direct care from any participating women's health care Provider for any of the following services:

- Maternity
- Gynecological
- Preventive care
- Other health problems discovered and treated during the course of the visit which are within the Provider's scope of practice

Hospitals are required to notify Molina within 24 hours, or the first business day, of any inpatient admissions (including deliveries) in order for hospital services to be covered. Prior authorization is still required for inpatient or outpatient surgeries. Please see Section 6, Medical Management for specific details.

Molina contracted Providers are also requested to notify the Healthcare Services Department at (800) 869-7185 when providing initial prenatal care to Members. This notification identifies Molina Members who may need to be monitored for high-risk pregnancies.

Family Planning Services

Molina members can self-refer to any family planning provider within the Molina provider network or to local health departments and family planning clinics paid by the State of Washington.

Enrollee Self Determination

Advance Directives are a written choice for health care. Under Washington State Law, there are two kinds of directives – Durable Power of Attorney for Health Care and Directive to Physicians. Written Advance Directives tell the PCP and other medical Providers how Members choose to receive medical care in the event they are unable to make end-of-life decisions. Each Molina Provider must honor Advance Directives to the fullest extent permitted under Washington State Law. Providers must document the presence of an Advance Directive in a prominent location of the medical record. PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance. Under no circumstances may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an Advance Directive.

- **Durable Power of Attorney for Health Care –** This Advance Directive names another person to make medical decisions on behalf of Members when they cannot make the choices for themselves. It can include plans about the care a Member wants or does not want and include information concerning artificial life-support machines and organ donations. This form must be signed, dated and witnessed by a notary public to be valid.

- **Directive to Physicians (Living Will) –** This Advance Directive usually states the Member wants to die naturally without life-prolonging care and can also include information about any medical care. The form would be used if the Member could not talk and death would occur soon. This directive must be signed, dated and witnessed by two people who know the Member well but are not relatives, possible heirs, or health care Providers.

- **Physician Orders for Life Sustaining Treatment (POLST)** - The POLST form represents a way of summarizing wishes of an individual regarding life-sustaining treatment. The form is intended for any individual with a serious illness. It accomplishes two major purposes:
    - It is portable from one care setting to another and it translates wishes of an individual into actual physician orders. An attending physician, ARNP or PA-C must sign the form and assume full responsibility for its accuracy.

When There Is No Advance Directive

The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must obtain informed consent prior to treatment from enrollees or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning Advance Directives (WAC 182-501-0125 and 42 CFR 438.6(m)); and, when appropriate, inform enrollees of their right to make anatomical gifts (Chapter 68.64 RCW).

BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and Covered Services for Molina Members enrolled in Washington Apple Health and Apple Health Integrated Managed Care (IMC) including:

- Apple Health with Premium (AHPREM) and Apple Health IMC with Premium (IMC-PREM)
- Apple Health Family/Pregnancy Medical (AHFAM) and IMC Family/Pregnancy Medical (IMC-AH)
- Apple Health Adult (AHA) and IMC Adult (IMC-AHA)
- Apple Health Blind Disabled (AHBD) and IMC (IMC-BD)
- Behavioral Health Services Only (BHSO)

While some benefits and Covered Services are the same, there are differences between the programs.

In addition to receiving health care services from providers who contract with Molina, Apple Health and IMC Members may self-refer and receive certain benefits through local community resources such as the Department of Health and Community Mental Health Clinics (CMHC) for the following:

- Family Planning Services
- Immunizations
- Tuberculosis (TB) screening and follow-up care
- Sexually Transmitted Disease (STD) treatment and follow-up care
- HIV or AIDS testing
- Women's Health Services
  - Maternity services including services from a midwife
  - Breast or pelvic exams
- Crisis Response Services (IMC Members only)
  - Crisis intervention, and,
  - Evaluation and treatment services

Washington Apple Health

Is Washington Medicaid's managed care program that includes Apple Health Managed Care and Integrated Managed Care. It is a prepaid, comprehensive system of medical and health care

delivery which includes preventive, primary, specialty and ancillary health services. HCA contracts with a number of health plans to provide health care to eligible Client groups.

Apple Health and IMC includes Clients eligible for:

- TANF
- Pregnant women with family incomes up to 193% of the federal poverty level (FPL)
- Children with family incomes up to 312% of FPL not eligible for other Medicaid programs Blind and Disabled (SSI) children and adults not eligible for Medicare
- Adult Medical or Medicaid Expansion up to 133% of FPL

Clients receive their health benefits by accessing care through providers who contract with a health plan.

Behavioral Health Services Only (BHSO)

BHSO is for specialty behavioral health services only. Specialty behavioral health is the term used for mental health and drug and alcohol treatment services. BHSO Members will continue to receive their physical health care benefits through other medical coverage such as; Medicare, private health insurance or the Medicaid fee-for-service network. Together with their physical health coverage, BHSO Members will have access to full coverage (physical health, specialty mental health and drug and alcohol treatment services).

Children's Health Insurance Plan (AHPREM) and (IMC-PREM)

AHPREM and IMC-PREM are a federal and state funded program, covering children under age 19, whose family's income is too high for Medicaid but below 312% of the FPL. HCA determines eligibility for AHPREM and enrolled children will be covered for a minimum of 12 months unless:

1. The family fails to pay the monthly premium for four months
2. The child's 19th birthday occurs before the end of the 12-month eligibility period
3. The child moves out of state

Molina is contracted to serve AHPREM and IMC-PREM Members in the same counties as our Apple Health and IMC service areas. Molina Members enrolled in the AHPREM and IMC-PREM program receive their health benefits by accessing care through providers contracted with the health plan.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is available to every Medicaid-eligible child under age 21. It includes screening (or well-child check-ups), diagnosis and treatment.

Please note that Molina adheres to the Bright Futures/American Academy of Pediatrics (AAP) Periodicity Schedule, found at https://www.aap.org/en-us/Documents/periodicity_schedule.pdff

The federal guidelines outlined below specify the minimum requirements included in each Well Child Care (WCC) exam for each of the following age groups; 0-18 months, 2-6 years, and 7-20 years. During the EPSDT visit, providers are required to deliver the following:

EPSDT Domain	Infants (0-18 months)	Children (2-6 years)	Adolescents (7-20 years)
Physical Exam and Health History	• History • Height • Weight • Physical exam (all of these)	• History • Height • Weight • Physical exam (all of these)	• History • Height • Weight • Physical exam (all of these)
Development and Behavior Assessment	• Gross motor • Fine motor • Social/emotional • Nutritional (any one of these)	• Gross motor • Fine motor • Communication • Self-help skills • Cognitive skills • Social/emotional • Regular physical activity • Nutritional (any one of these)	• Social/emotional • Regular physical activity • Nutritional (any one of these)
Mental Health Assessment	Mental health (must be addressed)	Mental health (must be addressed)	• Mental health • Substance abuse (either one of these)
Health Education/ Anticipatory Guidance	Examples are: • Injury prevention • Passive smoking (either one of these)	• Injury prevention • Passive smoking (either one of these)	• Injury prevention • STD prevention • Smoking/tobacco (any one of these)

Since 2003, Apple Health has used HEDIS Well-Child and Well-Adolescent measures to assess the health plans' rates for the number of children with qualifying EPSDT exams.

One of our goals at Molina is to improve children's health, as measured by our EPSDT rates. Your help with this effort is essential. If you have questions or suggestions related to well child care and EPSDT regulations, please call Member Services at (800) 869-7165.

Vaccines for Children

Since 1990, the Washington State Immunization Program has been providing vaccines to all children under the age of 19, regardless of their income level, through a combination of state and federal funds. In 1994, the federal government provided an additional funding source through the Vaccines for Children (VFC) program. The Centers for Disease Control and Prevention (CDC), which provides VFC funding, has developed strict accountability requirements from the state, local health jurisdictions, and individual providers. Molina Providers should be enrolled in the VFC program through their local health department.

State supplied vaccines are provided at no cost to enrolled providers through the local health department. Washington is a "universal vaccine distribution" state. This means no fees can be charged to patients for the vaccines themselves and no child should be denied state supplied vaccines for inability to pay an administration fee or office visit.

Molina follows HCA Medicaid Provider Guides for reimbursing a provider's administration costs. Providers must bill state-supplied vaccines with the appropriate procedure codes and a SL Modifier for identification and reporting purposes. More specific information regarding billing for state-supplied vaccines can be found on the Physician Related Services/Health Care Professional Services Provider Guide at https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides

Urgent Care Services

Urgent care services are covered by Molina without a referral or prior authorization. This also includes non-contracted providers outside of Molina's service area.

24-Hour Nurse Advice Line

Members may call (888) 275-8750 (TTY 711) anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week, to assess symptoms and help make good health care decisions.

Molina is committed to helping our Members:

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

These registered nurses do not diagnose, they assess symptoms and guide the patient to the most appropriate level of care following specially designed 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.

Washington Recovery Help Line

The Washington Recovery Help Line is the new consolidated help line for substance abuse, problem gambling and mental health, as authorized and funded by The Washington State Department of Social and Health Services' Division of Behavioral Health and Recovery. It is a 24-hour crisis intervention and referral line for those struggling with issues related to mental health, substance abuse, and problem gambling. Professionally trained volunteers and staff provide confidential support and referrals to detox, treatment, and recovery support groups. WA state residents can access services 24 hours a day at (866) 789-1511 or www.warecoveryhelpline.org.

PROVIDER RESPONSIBILITIES

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of

1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency and Members who are deaf, hard of hearing or have speech or cognitive/intellectual impairments. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, gender, gender identity, sexual orientation, age and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each. Additional information on cultural competency and linguistic services is available at www.molinahealthcare.com.

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/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. Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve members because they receive assistance with Medicare cost sharing from a State Medicaid Program.

Section 1557 Investigations

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

Molina Healthcare
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802
Toll Free: (866) 606-3889
TTY/TDD: 711
On Line: https://molinahealthcare.AlertLine.com
Email: civil.rights@molinahealthcare.com

Molina Institute for Cultural Competency

Molina is committed to reducing disparities. Training employees, Providers and their staff, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina founded the Molina Institute for Cultural Competency, which integrates Cultural

Competency training into the overall Provider training and quality monitoring programs. An integrated quality approach intends to enhance the way people think about our Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

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

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

1. Written materials;
2. On-site cultural competency training delivered by Provider Services Representatives;
3. Access to enduring reference materials available through Health Plan representatives and the Molina website; and
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement – Ensuring Access

Molina ensures Member access to language services such as oral interpreting, American Sign Language (ASL), written translation and access to programs, and aids and services that are congruent with cultural norms. Molina supports Members with disabilities, and assists Members with Limited English Proficiency.

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats, leading to better communication, understanding and Member satisfaction. Online materials found on www.molinahealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

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

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations with plan's membership
  - Revalidate data at least annually
  - Contracted Providers to assess gaps in network demographics

- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
- Applicable national demographics and trends derived from publicly available sources

- Network Assessment
- Collection of data and reporting for the Diversity of Membership HEDIS measure
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS and CAHPS results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.
- Comparison with selected measures such as those in Healthy People 2010

Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES) Linguistic Services

Molina provides oral interpreting of written information to any plan Member who speaks any non-English language regardless of whether that language meets the threshold of a prevalent non-English language. Molina notifies plan Members of the availability of oral interpreting services upon enrollment, and informs them how to access oral interpreting services at no cost to them on all significant Member materials. Molina serves a diverse population of Members with specific cultural needs and preferences. Providers are responsible for supporting access to interpreter services at no cost for Members with sensory impairment and/or who have Limited English Proficiency.

Documentation

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

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic member lists that are sent to you each month by Molina.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of his or her right to have a qualified interpreter at no cost.

Members with Hearing Impairment

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center (M&PCC), Quality, Healthcare Services and all other health plan functions.

Molina strongly recommends that Provider offices make available assistive listening devices for members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the provider's voice to facilitate a better interaction with the member.

Molina will provide face-to-face service delivery for ASL to support our members with hearing impairment. Requests should be made three days in advance of an appointment to ensure

availability of the service. In most cases, members will have made this request via Molina Member Services.

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

It is important for Providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Provider Network and Members. Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact Member access to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing at least thirty (30) days in advance, when possible, of changes such as, but not limited to:

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

Please visit our Provider Online Directory at https://providersearch.molinahealthcare.com to validate your information. Please notify your Provider Services Representative by fax at (877) 814-0342 or via e-mail at MHWProviderServicesInternalRep@Molinahealthcare.com if your information needs to be updated or corrected.

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

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Providers are required to provide timely responses to such communications.

National Provider Identifier (NPI) HCA Billing and Non-Billing Enrollment Requirements

Per federal regulation (42.C.F.R. 455.410(b)) providers who have a contract with the state's Medicaid agency or a contract with a Managed Care Organization (MCO) that serve Medicaid Clients must enroll with HCA under a Non billing or Billing agreement. The provider's National Provider Identifier (NPI) submitted on all claims must be the NPI registered with HCA.

Effective January 1, 2018, Molina will deny/reject all claims submitted to Molina for processing if billed with an NPI that is not enrolled with HCA or does not match what HCA identifies as the enrolled NPI number.

For additional information and to access the Non-Billing and Billing and servicing enrollment form, which must be used to register with HCA or to correct an NPI, visit the HCA website at http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-non-billing-individual-provider.

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools.

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

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

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by registering for Molina's Provider Web Portal, and submitting electronic claims upon entry into the network. Providers entering the network as a Contracted Provider must enroll for EFT/ERA payments within thirty (30) days of entering the Molina network.

If a Provider does not comply with Molina's Electronic Solution Requirements, the Provider's claim may be denied.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)
- Provider Web Portal

Electronic Claims Submission Requirement

Molina requires Participating Providers to submit claims electronically. Electronic claims submission provides significant benefits to the Provider including:

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Provider Portal. See our Provider Web Portal Quick Reference Guide https://provider.molinahealthcare.com or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 38336, refer to our website www.molinahealthcare.com for additional information.

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

- Ability to add attachments to claims
- Submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim

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

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, the ability to have searchable ERAs, and to receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery.

Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: www.molinahealthcare.com.
Any questions during this process should be directed to Change Healthcare Provider Services at wco.provider.registration@changehealthcare.com or 877-389-1160.

Provider Web Portal

Providers are required to register for and utilize Molina's Provider Web Portal (Provider Portal). The Provider Portal is an easy to use, online tool available to all of our Providers at **no cost**. The Provider Portal offers the following functionality:

- Verify and print member eligibility
- Claims Functions
  - Professional and Institutional Claims (individual or multiple claims)
  - Receive notification of Claims status change
  - Correct Claims
  - Void Claims
  - Add attachments to previously submitted claims
  - Check Claims status
  - Export Claims reports
  - Appeal Claims

- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization Requests
  - Check status of Authorization Requests
  - Receive notification of change in status of Authorization Requests

- View HEDIS® Scores and compare to national benchmarks

Balance Billing

Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for services that require prior authorization. Providers may not charge Members fees for covered services.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Balance billing a Molina Member for services covered by Molina is prohibited. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

For additional information please refer to the Claims and Compensation sections of this Provider Manual.

Out of Network Providers

Out of network provider must obtain prior authorization for all non emergent services and ensure any cost to the member is no greater than it would be if services were furnished as a participating provider.

Member Rights and Responsibilities

Providers are required comply with the Member Rights and Responsibilities as outlined in Member materials such as Member Handbooks. More information is available in the Member Rights and Responsibilities section in this Provider Manual.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and be approved by Molina prior to use. Please contact your Provider Services Representative for information and review of proposed materials.

Member Eligibility Verification

Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Possession of a Molina ID Card does not guarantee Member eligibility or coverage. A Provider must verify a recipient's eligibility each time the recipient presents to their office for services. More information on Member eligibility verification options are available in the Eligibility, Enrollment and Disenrollment section of this Manual.

Healthcare Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina's Healthcare Services programs and initiatives. Clinical documentation necessary to complete medical review and decision making is to be submitted to Molina through electronic channels such as the Provider Portal. Clinical documentation can be attached as a file and submitted securely through the Provider Portal. Please see the Medical Management section of the Manual for additional details about these and other Healthcare Services programs.

Clinical Data Repository Participation Requirements

Per Molina's contract with the Health Care Authority section 7.2.10.2.6 Cost to the subcontractors to program EHR systems or connect to the Health Information Exchange (HIE) are the responsibility of the individual entities. This means Molina network providers must participate in the WA Link4Health Clinical Data Repository (CDR) beginning no later than February 1, 2017 if your organization is already invested and using certified EHR technology. If your organization is receiving Medicaid or Medicare EHR incentive payments, it has already been determined that your system meets certification requirements. For more information you can visit:

- OneHealthPort website at http://www.onehealthport.com/cdr-overview

- HCA website at https://www.hca.wa.gov/about-hca/health-information-technology/clinical-data-repository-cdr

Referrals

When a Provider determines Medically Necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals (please refer to the Medical Management section of this Manual) unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and Specialist to coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina except in the case of urgent and Emergency Services. There may be circumstances in which referrals may require an out of network Provider; prior authorization will be required from Molina except in the case of Emergency Services.

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

Admissions

Providers are required to comply with Molina's facility admission, prior authorization, and Medical Necessity review determination procedures.

Participation in Utilization Review and Care Management Programs

Providers are required to participate in and comply with Molina's utilization review and Care Management programs, including all policies and procedures regarding prior authorizations. This includes the use of an electronic solution for the submission of documentation required for medical review and decision making. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

Continuity and Coordination of Provider Communication

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

Treatment Alternatives and Communication with Members

Molina endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and

facilitate training in self-care and other measures Members may take to promote their own health.

Prescriptions

Providers are required to adhere to Molina's drug formularies and prescription policies.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at www.molinahealthcare.com under the Health Resource tab. Please consult with your Provider Services representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

Participation in Quality Programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers.

Additional information regarding Quality Programs is available in the Quality Improvement section of this Manual.

Access to Care Standards

Molina is committed to providing timely access to care for all Members in a safe and healthy environment. Molina 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. See Section 7, Quality Improvement, for the required appointment standards.

Site and Medical Record-Keeping Practice Reviews

As a part of Molina's Quality Improvement Program, Providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices.

Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record (electronic preferred or hard copy) should contain all information required by State and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina's policies and procedures. Providers are to retain all such records for a minimum of ten (10) years and retained further if the records are under review or audit until the review or audit is complete.

CMS has specific guidelines for the retention and disposal of Medicare records. Please refer to CMS General Information, Eligibility, and Entitlement Manual, Chapter 7, Chapter 30.30 for guidance.

PCP Role in Assessing and Referring Members for Mental Health and Chemical Dependency Services

It is the primary care provider's (PCP) responsibility to assess if a member has any symptoms of a mental health or chemical dependency condition. If the results of the assessment are positive for mental health or chemical dependency issues, the PCP is responsible for referring the member to the appropriate mental health or chemical dependency services. In addition, it is the PCP's responsibility to support and encourage the member toward recovery and educate the member on the benefits of treating these conditions as well as the risks. Information on the principles of recovery and provider strategies to support recovery can be found on our Provider Website under page http://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf.

Referral for Mental Health Services

The mental health benefit for Apple Health Medicaid beneficiaries is a two-tiered benefit. Outpatient mental health services for mild to moderate mental health conditions including psychotherapy, psychological testing, and medication management are covered under the managed care benefit. Members may also self-refer for mental health services. Please see the Molina Provider website, or contact our Molina Member Services, for a list of participating mental health providers.

More intensive mental health services for members with more severe, chronic mental health conditions, including inpatient mental health, day treatment, and intensive case management services, are provided by the Regional Support Networks (RSNs) for members who meet Access to Care Standards. The RSNs maintain a crisis/access line for members to call for services. The RSNs contract with community mental health agencies and inpatient psychiatric facilities to deliver services. The Access to Care Standards https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/access-care-standards-acs-and-icd-information can be located on our Provider website, as well as information on how to refer to the RSNs and a list of RSN contracted providers https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/information-mental-health-providers.

If you are not sure where to refer a member you may always refer to a Molina provider for an initial evaluation. The Molina case management team will identify members who may meet Access to Care Standards and coordinate a referral to the appropriate RSN. Additional information on Medicaid Mental Health services is included in the Health Care Authority Mental Health Services Provider Guide http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides.

The behavioral health benefit for FIMC Medicaid beneficiaries is the managed care plans responsibility. The managed care plan is responsible for the intensive mental health services as well as substance use disorder services. For members enrolled in AH-FIMC you would refer members to one of the in network providers located on the Molina provider online directory.

Wraparound with Intensive Services (WISe) Providers

WISe providers are required to follow the program, policies and procedures contained within the Department of Social and Health Services (DSHS) Wraparound with Intensive Services (WISe) Manual, which is available: https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/wraparound-intensive-services-wise-implementation.

Referral for Chemical Dependency Services

All Apple Health Medicaid Chemical Dependency treatment services, with the exception of medical detox in a hospital setting, are provided fee-for-service for Medicaid beneficiaries. Services are delivered by state-licensed chemical dependency providers. Information on how to refer a member for Chemical Dependency services can be found at the Alcohol and Drug Abuse Services and Information https://www.dshs.wa.gov/bhsia/substance-use-treatment-services link on our Provider website. For members enrolled in AH-FIMC the managed care plan is responsible for covering these services. You can refer your patient to one of our network providers located on our provider online directory. You may also contact the Healthcare Services Department at (800) 869-7185.

Delivery of Patient Care Information

Providers must comply with all State and Federal Laws, and other applicable regulatory and contractual requirements to promptly deliver any Member information requested by Molina for use in conjunction with utilization review and management, grievances, peer review, HEDIS® Studies, Molina's Quality Programs, or claims payment. Providers will further provide direct access to patient care information (hard copy or electronic) as requested by Molina and/or as required to any governmental agency or any appropriate State and Federal authority having jurisdiction.

Compliance

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

Confidentiality of Member Protected Health Information (PHI) and HIPAA Transactions

Molina requires that contracted Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI.

Additionally, Providers must comply with all HIPAA TCI (transactions, code sets, and identifiers) regulations. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including claims submitted to Molina.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member appeals, the Provider will participate by providing

medical records or statement if needed. This includes the maintenance and retention of Member records for a period of not less than ten (10) years, and retained further if the records are under review or audit until such time that the review or audit is complete.

Please refer to Section 07, Quality Improvement information regarding this program.

Participation in Credentialing

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

Providers must notify Molina no less than thirty (30) days in advance when they relocate or open an additional office. More information about Molina's Credentialing program, including Policies and Procedures is available in the Credentialing section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegation Policies and Delegated Services Addendum. Please see Section 14, Delegation – Medical Group – IPA Operations for more information about Molina's delegation requirements and delegation oversight.

HEALTHCARE SERVICES

Introduction

Molina provides care management services to Molina Members using processes designed to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Molina utilizes an integrated care management model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Elements of the Molina medical management program include Pre-service review and Organization Determination/ Authorization management that includes pre-admission, admission and inpatient review, Medical Necessity review, and restrictions on the use of non-network Providers. You can contact the Molina UM Department toll free at (800) 869-7175. The UM Department fax number is (800) 767-7188.

Utilization Management

Molina's Utilization Management (UM) program ensures appropriate and effective utilization of services. The UM team works closely with the Care Management (CM) team to ensure Members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. To reflect the vital role this process plays in Molina's innovative HCS program, the UM program ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the levels of care needed for a Member. This program promotes the provision of quality, cost-effective and medically

appropriate services that are offered across a continuum of care, integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes as necessary and is designed to influence Member's care by:

- Identify medical necessity and appropriateness while managing benefits effectively and efficiently to ensure efficiency of the healthcare services provided
- Continually monitor, evaluate and optimize the use of healthcare resources while evaluating the necessity and efficiency of health care services across the continuum of care;
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization while monitoring utilization practice patterns of Providers, hospitals and ancillary Providers to identify over and under service utilization;
- Identify and assess the need for Care Management/Health Management through early identification of high or low service utilization and high cost, chronic or long term diseases;
- Promote health care in accordance with local, state and national standards;
- Identify events and patterns of care in which outcomes may be improved through efficiencies in UM, and to implement actions that improve performance by ensuring care is safe and accessible
- Ensuring that qualified health care professionals perform all components of the UM / CM processes while ensuring timely responses to Member appeals and grievances
- Continually seek to improve Member and Provider satisfaction with health care and with Molina utilization processes while ensuring that UM decision tools are appropriately applied in determining medical necessity decision.
- Process authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

The table below outlines the key functions of the UM program. All prior authorizations are based on a specific standardized list of services.

Eligibility and Oversight	Resource Management	Quality Management
Eligibility verification	Prior Authorization and Referral Management	Satisfaction evaluation of the UM program using Member and practitioner input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis
Ensuring authorized care correlates to Member's medical necessity need(s) & benefit plan	Retrospective Review	Monitor for possible over- or under-utilization of clinical resources
Verifying current Physician/hospital contract status	Referrals for Discharge Planning and Care Transitions	Quality oversight
Delegation oversight	Staff education on consistent application of UM functions	Monitor for adherence to CMS, NCQA, state and health plan UM standards

Medical Necessity Review

Molina only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to MCG (formerly known as Milliman Care Guidelines), McKesson InterQual®, other third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively.

All Providers must obtain authorization for specific services that require prior authorization, unless the requesting Provider is affiliated with a medical group/IPA granted "delegated" Utilization Management status (For information on contracted medical groups/IPAs that are delegated for UM please see Section 13, Delegation -Medical Group/IPA Operations**.** If you are treating a Member assigned to a PCP in one of the delegated medical groups/IPAs, Molina Providers are required to follow their specific authorization requirements, as they may restrict their referrals to Providers within their group.

Clinical Information

Molina 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 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 Hospital or Provider Services Agreement require such documentation to be acceptable.

Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina 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 prior authorization documents are updated annually and the current documents are posted on the Molina website. You can find the most current copy of the Authorization Request form at http://www.molinahealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx.

Requests for prior authorizations to the UM Department may be requested by telephone, fax, mail based on the urgency of the requested service, or via the Provider Web Portal. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number, etc.)
- Clinical information sufficient to document the Medical Necessity of the requested service
- Provider demographic information (referring Provider and referred to Provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS, and ICD-10 codes

- Location where service will be performed
- Member diagnosis (CMS-approved diagnostic and procedure code and descriptions)
- Pertinent medical history (include treatment, diagnostic tests, examination data)
- Requested Length of stay (for inpatient requests)
- Indicate if request is for expedited or standard processing

Molina will process any non-urgent requests within five (5) calendar days of the receipt of necessary information, but are allowed up to fourteen (14) calendar days, if additional information is required and requested by the Contractor within five (5) calendar days of the original receipt of the request for services. For all urgent requests, the decision must be made within forty-eight (48) hours of receipt of request.

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 does not "retroactively" authorize services that require prior authorization unless the request falls under WAC 284-43-2060 Extenuating Circumstances in Prior Authorization.

Molina will not administratively deny late notifications (requests for inpatient services greater than 24 hours or next business day from admission) when an extenuating circumstance adversely affects the ability of the participating provider or facility to request prior authorization prior to the service delivery as long as the services are covered benefits for the member and meet Molina medical necessity criteria.

Molina requires a participating provider or facility to submit documentation before a claim is submitted or within 14 days of claims submissions for consideration of prior authorization for extenuating circumstances. Submissions after this time frame will be considered an appeal and follow the timely filing for appeals submissions. When submitting your prior authorization request, clearly document the request is an Extenuating Circumstance and outline the Extenuating Circumstance in this case that prevented the provider from being able to request prior authorization or notification as required.

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 has a full-time Medical Director available to discuss medical necessity decisions with the requesting provider at (800) 869-7158.

Requesting Prior Authorization

Please indicate if the request is urgent or non-urgent. The Definition of expedited/urgent is when the situation where the standard time frame or decision making process could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function. If the member is assigned to a delegated Medical Group/IPA, please send the prior authorization request to the Medical Group/IPA.

WebPortal

Providers are required to use the Molina WebPortal for prior authorization submissions whenever possible. Instructions for how to submit a Prior Authorization Request are available on the Portal. You can click on the following link to take you to the login page:

https://eportal.molinahealthcare.com/Provider/login
Phone:

- Molina Healthcare: (855) 322-4082
- Kaiser Foundation Health Plan of the Northwest: (800) 813-2000
- Confluence Health : (800) 691-1224

Fax: If the request is not on the form provided in this manual, be sure to send to the attention of the Healthcare Services Department. Please include the supporting documentation needed for Molina to make a determination.

- Molina Healthcare:
  Medical/Behavioral Health (800) 767-7188
  Advanced Imaging (877) 731-7218
  Inpatient Census (800) 413-3806
  NICU (877) 731-7220
  Transplant (877) 813-1206
- Kaiser Foundation Health Plan of the Northwest: (877) 800-5456
- Confluence Health: (509) 665-3606

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

Molina Healthcare of Washington
Attn: Healthcare Services Dept.
PO Box 4004
Bothell, WA 98041-4004

Genetic Lab Testing and Prior Authorization

Currently Molina requires prior authorization for genetic testing. Effective September 1, 2018 Molina Healthcare of Washington will require that Quest or Lab Corp be used for these lab services. If other labs are used these services will be redirected to Quest or Lab Corp. If the lab sample is in route to a lab other than Quest or Lab Corp, before the prior authorization is requested, the lab sample will need to be redirected before authorized. If an exception is required the ordering physician must send in a request along with a letter explaining why an exception should be considered. The request will be reviewed by a Medical Director.

Affirmative Statement about Incentives

Molina requires that all medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns and ensures, through communications to Providers, Members, and staff, that Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members. Furthermore, Molina affirms that all UM decision making is based only on appropriateness of care and service and existence of coverage for its Members, and not on the cost of the service to either Molina or the delegated group. Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care. It is important to remember that:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care.
- UM decision makers do not receive incentives to encourage decisions that result in underutilization.

Open Communication about Treatment

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

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

Utilization Management Functions Performed Exclusively by Molina

The following UM functions are conducted by Molina (or by an entity acting on behalf of Molina) and are never delegated:

1. Transplant Case Management - Molina does not delegate management of transplant cases to the medical group. Providers are required to notify Molina's UM Department when the need for a transplant evaluation has been identified. Contracted Providers must obtain prior authorization from Molina Medicare for transplant evaluations and surgery. Upon notification, Molina conducts medical necessity review. Molina selects the facility to be accessed for the evaluation and possible transplant.
2. Clinical Trials - Molina does not delegate to Providers the authority to determine and authorize clinical trials. Providers are required to comply with protocols, policies, and procedures for clinical trials as set forth in Molina's contracts.
3. Experimental and Investigational Reviews - Molina does not delegate to Providers the authority to determine and authorize experimental and investigational (E & I) reviews.

Delegated Utilization Management Functions

Medical Groups/IPAs delegated with UM functions must be prior approved by Molina and be in compliance with all current Molina policies. Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities depending on their ability to meet, perform the delegated activities and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Communication and Availability to Members and Providers

Molina HCS staff is accessible at (800) 869-7175 during normal business hours, from 7:30 a.m. to 6:30 p.m. Monday – Friday excluding holidays for information and authorization of care. When initiating, receiving or returning calls the UM staff will identify the organization, their name and title.

Molina's Nurse Advice Line is available to Members and Providers 24 hours a day, seven days a week at (888) 275-8750. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters. . Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. Providers can also utilize fax and the Provider Portal for after-hours UM access, as described later in this section

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff. Callers may also contact staff directly through a private line. All staff Members identify themselves by providing their first name, job title, and organization.

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

Molina's Provider Portal is available twenty-four (24) hours per day, seven (7) days per week. The Portal can be used for Prior Authorization functions (requests, status checks, etc.) and communication.

Levels of Administrative and Clinical Review

Molina reviews and approves or denies plan coverage for various services—inpatient, outpatient, medical supplies, equipment, and selected medications. The review types are:

- Administrative (e.g., eligibility, appropriate vendor or Participating Provider, covered services) and
- Clinical (e.g., Medically Necessary)

The overall review process begins with administrative review followed by initial clinical review if appropriate. Specialist review may be needed as well. All Determination/Authorization requests that may lead to denial are reviewed by a heath professional at Molina (medical directory, pharmacy director, or appropriately licensed health professional).

All staff involved in the review process has an updated Determination/Authorization requirements list of services and procedures that require Pre-Service Organization Decision/Authorization.

The Determination/Authorization requirements, timelines and procedures are published in the Provider Manual and are available on the www.molinahealthcare.com website.

In addition, Molina's Provider training includes information on the UM processes and Determination/Authorization requirements.

Emergency Services

Emergency Services means: a medical screening examination, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that Emergency Medical Condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital.

Emergency or Emergency Medical Condition means: the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including sever pain, which in the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in jeopardy to the person's health, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or disfigurement to the person; in in the case of a pregnant woman, serious jeopardy to the health of the fetus.

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent Emergency Services rendered to the Member do not require prior authorization from Molina.

Members accessing the emergency department inappropriately will be contacted by Molina 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 within twenty four (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.

Certified Public Expenditure (CPE) Hospitals

If your facility is identified as a CPE hospital your hospital is eligible to be compensated for inpatient services provided to the Apple Health Blind and Disabled (AHBD) or Integrated Managed Care Blind and Disabled (IMCBD) population through the certified public expenditure program. You will need to bill all inpatient services for AHBD and IMCBD members to Washington State Medicaid. In order to be compensated for services you must obtain prior authorization from the members' health plan in advance of providing the service. When you bill Washington State Medicaid you will need to include the health plan authorization number in the comments or notes section on the claim. The professional component is the responsibility of the health plan and should be billed directly to the health plan.

Elective Inpatient Admissions

Molina 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 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. For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina 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 or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.

Prospective/Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests. Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health, some durable medical equipment (DME) and Out-of-Area/Out-of-Network Professional Services. The pre-service review process assures the following:

- Member eligibility;
- Member covered benefits;
- The service is not experimental or investigation in nature;
- The service meets Medical Necessity criteria (according to accepted, nationally-recognized resources);
- All covered services, e.g. test, procedure, are within the Provider's scope of practice;
- The requested Provider can provide the service in a timely manner;
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition;
- The requested covered service is directed to the most appropriate contracted specialist, facility or vendor;
- The service is provided at the appropriate level of care in the appropriate facility; e.g. outpatient versus inpatient or at appropriate level of inpatient care;
- Continuity and coordination of care is maintained; and
- The PCP is kept appraised of service requests and of the service provided to the Member by other Providers.

Inpatient Review

Molina performs concurrent inpatient review in order to ensure patient safety, Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an inpatient, for those stays where there is a clear expectation, and the medical record supports that reasonable expectation of an extended stay, or

where observation has been tried, in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed.

Inpatient Status Determinations

Molina's UM staff determine if the collected medical records and clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and Medical Necessity requirements. To determine Medical Necessity, the criteria outlined under "Medical Necessity Review" will be used.

Discharge Planning

Discharge planning begins on admission, and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. Upon discharge the Provider must provide Molina with Member demographic information, date of discharge, discharge plan and disposition.

Concurrent Review Nurses work closely with the hospital discharge planners to determine the most appropriate discharge setting for the patient. The concurrent review nurses review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Post Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina for services that require authorization. Failure to obtain authorization for an elective service that requires authorization will result in an administrative denial. Emergent services do not require authorization. Coverage of emergent services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied.

Failure to obtain authorization when required will result in denial of payment for those services, unless the request falls under WAC 284-43-2060 Extenuating Circumstances in Prior Authorization.

Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, CMS Medical Coverage Guidelines, Local and National Coverage Determinations, CMS Policy Manuals, regulation and guidance and evidence based criteria sets.
Specific Federal or State requirements or Provider contracts that prohibit administrative denials supersede this policy.

Readmission

Effective 01/01/2018 HCA is implementing a new readmission policy. All Medicaid health plans and FFS will follow a common policy which contains specific provider requirements in discharge and follow-up planning. Determination and recoupment will be retroactive and applies

only to medically necessary readmissions. Critical Access hospitals are excluded from this policy.

Administrative Days

Hospitals requesting authorization of administrative days must submit a separate authorization request from the inpatient hospital stay. Molina requires the following information be included in the request for authorization:

- Current clinical data
- Submission of documented discharge/placement efforts
- Documentation of phone call and fax responses regarding placement to include specific information of contacted providers
- Documentation of specific rationale for declines related to placement
- Plan of care including specific needs and long term goals

If during the continuation of administrative days the member's condition is such that custodial care may be appropriate, you will be directed to Home and Community Services (HCS) for future discharge and placement needs. If the member's diagnosis includes chemical dependency issues, you must refer the member to Department of Social and Health Services (DSHS) for possible chemical dependency treatment.

Administrative days must be billed on a separate claim form:

- For acute care stay paid under DRG - revenue code 0191 must be billed on the claim for administrative days and the acute care stay claim must be billed with inpatient status code 30 to indicate a separate claim will be submitted for administrative days
- For per-diem - paid services bill with revenue code 0169

Non-Network Providers

Molina maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Members. Molina requires Members to receive medical care within the participating, contracted network of providers unless it is for emergent/urgent services. Non-network providers may provide emergent/urgent services for a member without prior authorization or as otherwise required by Federal or State laws or regulations.

If there is a non-emergent need to go to a non-contracted provider, all care provided by the non-contracted, non-network provider must be prior authorized by Molina.

Avoiding Conflict of Interest

The HCAS Department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.
Molina does not reward providers or other individuals for issuing denials of coverage or care. Furthermore, Molina never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. Molina also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care and Services

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

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

It is also Molina's policy to allow continuity of care for new Members who become effective with Molina and meet the above conditions. All requests will be reviewed by the Medical Director. For additional information regarding continuity of care and transition of Members, please contact Molina at (800) 869-7175.

Organization Decisions

A decision is any determination (e.g., an approval or denial) made by Molina or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to deny requests (adverse benefit determination);
- Discontinuation of a service;
- Payment for temporarily out-of-the-area renal dialysis services;
- Payment for Emergency Services, post stabilization care or urgently needed services;

All Medical Necessity requests for authorization determinations must be based on nationally recognized criteria that are supported by sound scientific, medical evidence. Clinical information used in making determinations include, but are not limited to, review of medical records, consultation with the treating Providers, and review of nationally recognized criteria. The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

Clinical criteria does not replace State regulations when making decisions regarding appropriate medical treatment for Molina Members. Molina covers all services and items required by State.

Requests for authorization not meeting criteria must be reviewed by a designated Molina Medical Director or appropriate clinical professional. Only a licensed physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) may determine to delay, modify or deny services to a Member for reasons of medical necessity.

Board certified licensed Providers from appropriate specialty areas must be utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions must be made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal regulatory requirements and NCQA standards.

Providers can contact Molina's Healthcare Services department at (800) 869-7175 to obtain Molina's UM Criteria.

Reporting of Suspected Abuse of an Adult

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

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

- Molina employees who have knowledge or suspect the abuse, neglect, or exploitation;
- Law enforcement officer;
- Social worker; Professional school personnel; Individual Provider; an employee of a facility; an operator or a facility; and/or
- An employee of a social service, welfare, mental/behavioral health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science Provider or healthcare Provider.

A permissive reporter is any individual with knowledge of a potential abuse situation who is not included in the list of mandatory reporters. A permissive reporter may report to the Molina UM

Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited or neglected. Permissive or voluntary reporting will occur as needed.

The following are the types of abuse which are required to be reported:

- Physical abuse is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints.
- Sexual abuse is nonconsensual sexual contact. Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing.
- Mental/behavioral mistreatment is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; and yelling or swearing which results in mental distress.
- Neglect occurs when someone, either through action or inaction, deprives a vulnerable adult of care necessary to maintain physical or mental health.
- Self-neglect occurs when a vulnerable adult fails to provide adequately for themselves. A competent person who decides to live their life in a manner which may threaten their safety or well-being does not come under this definition.
- Exploitation occurs when a vulnerable adult or the resources or income of a vulnerable adult are illegally or improperly used for another person's profit or gain.
- Abandonment occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter or health care.
-

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

Office of the Attorney General's Vulnerable Adult Abuse reporting line at:
(866) 363-4276 (866-END-HARM).

All reports should include:

- Date abuse occurred;
- Type of abuse;
- Names of persons involved if known;
- Any safety concerns.

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

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

Emergency Services

Emergency Services means: a medical screening examination, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital.
Emergency services are covered on a (24) hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition.
Molina Healthcare of Washington 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 of Washington contracts with vendors that provide (24) hour emergency services for ambulance and hospitals. In the event that our member is outside of the service area, Molina is prepared to authorize treatment to ensure that the patient is stabilized.

Continuity and Coordination of Provider Communication

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

Care Management

Molina Care Management includes Health Management (HM) and Case Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services.

PCP Responsibilities in Care Management Referrals

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

Care 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 Management

Molina's Health Management programs can be incorporated into the Member's treatment plan to address the Member's health care needs. Primary prevention programs may include smoking cessation and weight management and disease-specific health management programs for Asthma and Depression. Refer to "Benefits and Covered Services" section for detailed information regarding these services.

Case Management (CM)

Molina 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 needs through a continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina 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 case manager will arrange individual services for members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina 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 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)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately

- Children with Special Health Care Needs

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

Phone: 800) 869-7185
Fax: (800) 767-7188

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 records shall be maintained in accordance with State and Federal law, and for a period not less than ten (10) years.

Medical Necessity Standards

"**Medically Necessary**" or "**Medical Necessity**" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient. This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be 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. This literature is generally recognized by the relevant medical community, physician specialty society

recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, 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 a vendor, designated by Molina.

CVS/Caremark Specialty Pharmacy operates as a business unit within CVS/Caremark Corporation. The Member and Provider dispensing capabilities of McKesson Specialty Pharmaceuticals complement McKesson's existing patient relationship and disease management businesses, which hold market-leading positions.

When a Molina Member needs an injectable medication, the prescription can be submitted to Molina by fax at (800) 869-7791. Specialized request forms can be obtained by calling (800) 237-2767 or at http://www.molinahealthcare.com/providers/wa/medicaid/forms/PDF/forms_wa_Specialtydrugrequestform.pdf.

CVS/Caremark Specialty Pharmacy will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each patient, 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.

Transitions of Care

During episodes of illness involving multiple care settings, patients are at increased risk of poor health outcomes and avoidable re-admissions resulting from fragmented care if care transitions are not well executed. Molina designed its patient-centered Transitions of Care (ToC) program to improve the quality of care for patients with complex physical, long-term, and behavioral health care needs as they transition across care settings. Transitions of Care programs have been shown to reduce preventable re-admissions, emergency department use, and to improve health outcomes.

Molina defines Transitions of Care to include all services required to ensure the coordination and continuity of care from one care setting to another as the member's health status changes. This includes members discharging from medical, psychiatric, and chemical dependency inpatient treatment facilities and others. Molina's Transitions of Care team will confirm and re-establish the patient's connection to their medical home/Primary Care Physician/Specialist and assist with the coordination of care as the patient moves from one care setting to another. The target populations for Molina's Transitions of Care program are patients that are at a high risk of re-admission, based on medical literature and 30 years of experience serving the Medicaid population. These include members with a diagnosis of:

- Asthma
- Cellulitis
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Diabetes
- Pneumonia
- Chronic mental illness
- Substance abuse disorder
- Additional secondary criteria will be considered based on acuity and may include, but are not limited to, the following:
    - Member history of re-admission and poor adherence to follow-up treatment
    - Alzheimer's disease
    - Parkinson's disease
    - Multiple co-morbid conditions

Molina's ToC program focus is patient-centered collaborative care coordination. Our Transitions team works closely with Case Management, In-Patient Review Discharge Planners, Disease Management, Health Home staff, Community Health Workers, Pharmacy, providers, and care givers. This proactive collaboration helps assess for and remove barriers prior to discharge. This interdisciplinary approach ultimately results in improved health outcomes and reduced re-admissions. The ToC Team provides oversight to assure appropriate collaboration and confirms the members identified needs have been addressed. Weekly case review meetings led by a Molina Medical Director allow for discussion and planning for complex and difficult transitions. Molina patients may be contacted by a Transitions of Care Coach via a face-to-face or telephonic visit while in the inpatient setting. The Transitions of Care coach with the facility care team works to develop an individual care transition plan and personal health record. Following discharge, the patient may receive a follow-up phone call within 2-3 days after discharge, and a face-to-face visit in their place of residence within one week after discharge if needed. The Transitions of Care Coach will assess the patient's ability to make and attend all needed follow up appointments, complete medication reconciliation, nutrition management, patients understanding of illness and how to recognize worsening symptoms, when to call their Primary Care Physician, and develop a sick day plan, assess home safety, the member's support network and community connections, and will assist the member with obtaining immediate psychosocial needs such as food, transportation, clothing, social support, advocacy, and other community-based resources. The Transitions of Care Coach will continue to provide care coordination for 4 weeks, primarily via telephone, to ensure that the goals of the individual have been met and a member has successfully transitioned to a lower level of care. As the transitions of care process nears completion, Molina's Transitions of Care coordinator will identify any on-going needs that a member may have and, if needed, coordinate a referral to the Molina Case Management program or Primary Care Physician who will work with the member to address those needs going forward.

Molina's standard of care for Transitions of Care include the following and requires these elements be completed by the facilities, Primary Care Provider, Molina Contracted Staff, Case Managers, or Molina Transitions of Care coach for each patient as they transition between care settings.

- ❖ Assess and stratify patients into levels of risk for re-admission

- ❖ Create an individual patient plan to mitigate readmission to include:
    - Patient education to support discharge care needs for example: Medication management, ensure follow up appointments are attended, self-management of conditions, when and how to seek medical care. Planning is to include caregivers as needed,
    - Written discharge plan must be given to patient/caregiver and Primary Care Provider upon discharge,
    - Provider will ensure access to follow up appointment within 7 days of discharge.
    - Schedule follow up outpatient mental health or PCP appointments within 7 calendar days of discharge or ensure Home Care services are delivered within 7 days of discharge,
    - Organize post discharge services, home care services, and therapies, etc.,
    - Telephonic reinforcement of discharge plan and needed problem solving within 2-3 business days from time of discharge,
    - Information on what to do if a problem arises following discharge,
    - For patients at high risk of re-hospitalization, provide onsite care coordinator at time of discharge (Molina may have ToC coach or contracted staff round at facility),
    - For patients at high risk of re-hospitalization, Primary Care Provider or Molina (Molina contracted staff) will visit patient residence or secondary facility such as skilled nursing facility or residential mental health facility within 7 calendar days post discharge as needed to support discharge instructions, assess environment safety, conduct medicine reconciliation, assess adequacy of support network and services, link to appropriate referrals.

Planning activity should include patient's family and caregivers and support network in assessing needs.

Members engaged in Health Homes program will receive Transitions of Care services from Health Homes Care Coordinator.

To prevent duplication of services Molina will coordinate required elements with admitting facilities and assist in providing required elements that admitting facilities are unable to provide. Molina has developed operational agreements with Regional Support Networks, targeted substance use disorder treatment facilities, long-term care facilities, and behavioral and physical health facilities to communicate and collaborate on members' transitions through different levels of care. These operational agreements include guidelines for sharing the following information:

- Notification to Molina and Primary Care Physician of member admission.
- Written discharge plan provided to both the member and Primary Care Physician.
- Discharge planning including scheduled follow-up visits.
- Coordination of services needed upon discharge.
- Notification to Molina and Primary Care Physician of discharge.

When warranted for HIPAA compliance, Molina will obtain releases from members to allow sharing of data.

Health Home Services

Health Home implementation is authorized by Section 2703 of the federal Patient Protection and Affordable Care Act, the managed fee-for-service demonstration model, and the Substitute Senate Bill 5394 from the 2011 legislative session. Under Washington State's approach, Health Homes (HH) is the bridge to integrate care within existing health delivery systems.

A Health Home is the central point for directing patient-centered care for high-risk, high-cost beneficiaries in a specified geographic coverage area. The Health Home is accountable for reducing avoidable healthcare costs, specifically preventable hospital admissions/re-admissions, and avoidable emergency room visits. The Health Homes will provide timely post-discharge follow-up with the goal to improve patient outcomes by providing intensive care coordination services to high-cost, high-need Medicaid and Medicaid/Medicare beneficiaries to ensure that services are integrated and coordinated across medical, mental health, chemical dependency, long-term services and supports, and community support services.

Molina Healthcare of Washington is a qualified Health Home (AKA "lead entity") for geographic area 1 (Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, and Thurston Counties); area 2 (Island, San Juan, Skagit, and Whatcom Counties); and area 6 (Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman Counties). Molina is contracted with qualified lead entities in 3 other areas across the state to provide Health Home services. King and Snohomish counties are not participating in the Health Home demonstration. As a qualified lead entity, Molina is responsible for providing (or contracting for) the following six (6) specific care coordination services functions:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitions care from inpatient to other settings, including appropriate follow-up
- Individual and family support, including authorized representatives
- Referral to community and social support services
- Use of health information technology to link services, as feasible and appropriate

As a lead entity, Molina has created integrated provider networks in the above areas to ensure physical health, mental health, chemical dependency, long term services and social support needs can be met through an integrated collaborative approach.
Molina has contracted with various qualified Care Coordination Organizations (CCO) who will hire a team of care coordination staff responsible for delivery of face-to-face interactions with qualified Health Home enrollees. Molina is also functioning as a direct (CCO) to provide direct member interactions in limited areas.

The care coordination staff will be a combined team of clinical Case Managers and non-clinical community health workers. The dedicated care coordination staff will provide individual enrollee interactions aimed at delivery through six (6) Health Home elements of care coordination (see previous description).
The Health Care Authority will determine eligibility for the Health Home program and passively enroll eligible beneficiaries into the contractor's Health Home program. Those determined eligible for Health Home must have at least one chronic condition and be at-risk of a second, as determined by a minimum predictive risk score (PRISM) of 1.5.

Every member will have the ability to consent to Health Home services, withdraw from Health Home services, or opt-out of Health Home services.

The Clinical care coordinator will be responsible for informing and coordinating services with a member's current medical team and other community support services. When your client is receiving Health Home services you will be notified by the care coordinator.
If you would like more information about Health Homes and Molina's Health Home program, information can be found at Molinahealthcare.com, click on the "for healthcare professionals" tab. Open the "Health Resources" tab and click the Health Home category (or follow the attached link):

http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/healthhomes.aspx

Cancellation of Prior Authorized Services

Molina has implemented a process of canceling prior authorized services if the Member has lost eligibility. Molina's process is as follows:

1. Molina limits the authorization time frame to the current calendar month (i.e., all services will need to be rendered during the calendar month in which the authorization is issued); or
2. Molina sends a written notice that a Member's eligibility will be terminating at the end of a given month, and any previously issued authorization(s) will be cancelled as of the last day of the month if services are not rendered by the last day of the month. This notice is sent to the rendering Provider, Member's PCP and the Member.

Second Medical/Surgical Opinion

A Member may request a second medical/surgical opinion at any time during the course of a particular treatment, in the following manner:

- Molina Members may request a second opinion about the care they are receiving at any time.
- The member may request the Second Opinion through their assigned PCP or through Molina's Member Service Department.
- Second opinion consultations with participating practitioners, arranged by the member's PCP, do not require review or prior approval by Molina.

- A Member Services representative can assist the Member in coordinating the second opinion request with the Member's PCP, specialist and/or medical group/IPA.
- An approval to a non-participating Provider will be facilitated by Molina or the medical group/IPA if the requested specialty care Provider or service is not available within the Molina network.
- The appointment for the second opinion will occur within thirty (30) days of the request. The Member may request to postpone the second opinion to a date later than 30 days.
- The Medical Director may request a second opinion at any time on any case deemed to require specialty Provider advisor review.

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 has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (425) 424-1100 or (800) 869-7175.

Wrong Site Surgery

If it is determined a wrong site surgery was performed, Molina will not reimburse the providers responsible for the error.

QUALITY IMPROVEMENT

Quality Improvement

Molina Healthcare of Washington maintains a Quality Improvement (QI) Department to work with Members and Providers in administering the Molina Quality Improvement Program. You can contact the Molina QI Department **toll free at** (800) 423-9899, Ext. 141428 **or fax** (800) 767-7188.

The address for mail requests is:

Molina Healthcare of Washington, Inc.
Quality Improvement Department
25140 30th DR SE Ste. 400
Bothell, WA 98021

This Provider Manual contains excerpts from the Molina Healthcare of Washington Quality Improvement Program (QIP). For a complete copy of Molina Healthcare of Washington'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.

Patient Safety Program

Molina Healthcare's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Healthcare Members in collaboration with their Primary Care Providers. Molina Healthcare continues to support safe personal health practices for our Members through

our safety program, pharmaceutical management and case management/disease management programs and education. Molina Healthcare monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) is to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

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

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 Providers (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.

Medical Record Keeping Practices

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

Content

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

- 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;
- Problem list, including medical and behavioral health conditions;
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Allergies and adverse reactions are prominently displayed. Absence of allergies is noted in easily recognizable location;
- Advanced Directives are documented for those 18 years and older;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- 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 Member's health status;
- Chronic conditions are listed or noted in easily recognizable location;
- Treatment plans are consistent with diagnosis
- 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;
- Chronic conditions are listed or noted in easily recognizable location;
- Treatment plans are consistent with diagnoses;
- There is appropriate notation concerning use of substances, and for patients, there is evidence of substance abuse query;
- Consistent charting of treatment care plan;
- Working diagnoses are consistent with findings;
- 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 and filed in chart;
- Lab and other studies are initialed by ordering Provider upon review;
- 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 Provider admitted a patient to the hospital in the past twelve (12) months, the discharge summary must be filed in the medical record;
- 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;
- Chart sections are easily recognized for retrieval of information; and
- A release document for each Member authorizing Molina to release medial information for facilitation of medical care.

Retrieval

- The medical record is available to Provider at each Encounter;
- The medical record is available to Molina for purposes of Quality Improvement;
- The medical record is available to the External Quality Review Organization 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 record is maintained for not less than ten (10) years ; and
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

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

- Ensure that medical information is released only in accordance with applicable Federal or State law in pursuant to court orders or subpoenas;
- Maintain records and information in an accurate and timely manner;
- Ensure timely access by Members to the records and information that pertain to them;
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health an enrollment information;
- 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** (800) 423-9899, Ext 141428. See also the Compliance Section of this Provider Manual for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted primary PCPs (adult and pediatric) and participating specialist (to include OB/Gyn, behavioral health practitioners, and high volume and high impact specialists). 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 Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted:

Primary Care Appointment Type	Appointment Wait Time
Preventive Care Appointment	Within 30 calendar days of request
Second Opinions	Within 30 calendar days of request
Routine Primary Care	Within 10 calendar days of request
Urgent Care	Within 24 hours
Emergency Care	Available by phone 24 hours/seven days
After-Hours Care	Available by phone 24 hours/seven days
Office Waiting Time	Should not exceed 30 minutes
Care Transitions – PCP Visit	Within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program
Care Transitions – Home Care	If applicable, Transitional health care by a home care nurse or home care registered counselor within 7 calendar days of discharge from a substance use disorder treatment program, if ordered by the enrollee's primary care provider or as part of the discharge plan
Behavioral Health Appointment Types	**Appointment Wait Time**
Life Threatening	Immediately
Non-Life Threatening	Within 6 hours
Urgent Care	Within 24 hours
Routine Care	Within 10 calendar days

Office Wait Time

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

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 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. The service or recorded message should instruct Members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room.

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;

2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the **Molina QI Department toll free at (800) 423-9899, Ext. 141428 or TTY/TDD 711**;

3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;

4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language translation;

5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and

6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

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

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 Washington as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to Participating Providers for obstetrical and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on access to care is available under the Resources tab on the Molinahealthcare.com website or from your local Molina QI Department **toll free at (800) 423-9899, Ext. 141428**.

Monitoring Access Standards

Molina monitors compliance with the established access standards above. At least annually, Molina conducts an access audit of randomly selected contracted Provider offices to determine if appointment access standards are met. All appointment standards are addressed. Results of the audit are distributed to the Providers 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, Grievances and Appeals 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 (800) 423-9899, Ext. 141428**.

Quality of Provider Office Sites

Molina has a process to ensure that the offices of all Providers meet its office-site and medical record keeping practices standards. Molina continually monitors Member complaints for all office sites to determine the need of an office site visit and will conduct office site visits within sixty (60) calendar days. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This form includes the Office Site Review Guidelines and the Medical Record Keeping Practice Guidelines (as outlined above under Medical Records heading) 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
- Adequacy of medical/treatment record keeping

Physical accessibility

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

Physical appearance

The site visits includes, but is not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety.

Adequacy of waiting and examining room space

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

Adequacy of medical record-keeping practices

During the site-visit, Molina discusses office documentation practices with the Provider or Provider'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 the areas described in the Medical Records section above. To ensure Member confidentiality, Molina reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

Monitoring Office Site Review Guidelines and Compliance Standards

Provider office sites must demonstrate an overall 80% compliance with the Office Site Review Guidelines listed above. 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.

Administration & Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
- 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.
- 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.
- 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.

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 Provider that identifies the compliance issues.
- Send sample forms and other information to assist the Provider to achieve a passing score on the next review.
- Request the Provider to submit a written corrective action plan to Molina within thirty (30) calendar days.
- Send notification that another review will be conducted of the office in six (6) months.

When compliance is not achieved, the Provider will be required to submit a written corrective action plan (CAP) to Molina within thirty (30) calendar days of notification by Molina. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager or Provider 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 Provider is included in the Provider's 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.

Providers 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)

Molina complies with the advance directives requirements of the States in which the organization provides services. Responsibilities include ensuring members receive information regarding advance directives and that contracted practitioners and facilities uphold executed documents**.**

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 Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

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

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

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.

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

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Within thirty (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's standards may result in a corrective action plan (CAP) with a request the Provider submit a written corrective action plan to Molina within thirty (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.

Health Management

The Molina Health Management Program provides for the identification, assessment, stratification, and implementation of appropriate interventions for members with chronic diseases. For additional information, please see the Health Management heading in the Healthcare Services section of this Provider Manual.

Care Management

Molina's Care Management Program involves collaborative processes aimed at meeting an individual's health needs, promoting quality of life, and obtaining best possible care outcomes to meet the Member's needs so they receive the right care, at the right time, and at the right setting. Molina Healthcare Management includes Health Management (HM) and Case Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services. For additional information please see the Care Management heading in the Healthcare Services section of this Provider Manual.

Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or 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
Attention Deficit Hyperactivity Disorder (ADHD)
Chronic Obstructive Pulmonary Disease (COPD)
Depression
Diabetes
Heart Failure
Hypertension
Obesity

The adopted CPGs are distributed to the appropriate 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 Website. Individual Providers or Members may request copies from your local Molina QI Department **toll free at (800) 423-9899, Ext. 141428**.

Preventive Health Guidelines

Molina 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:

- Perinatal/Prenatal Care
- Care for children up to 24 months old
- Care for children 2-19 years old
- Care for adults 20-64 years old
- Care for adults 65 years and older
- Immunization schedules for children and adolescents
- Immunization schedules for adults

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

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®);
- Qualified Health Plan (QHP) Enrollee Experience Surveys;
- Experience of Care and Health Outcomes (ECHO®)
- Provider Satisfaction Survey; and
- Effectiveness of Quality Improvement Initiatives.

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

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

Molina's most recent results can be obtained from your local Molina QI Department toll free at **(800) 423-9899, Ext. 141428** or fax (800) 767-7188 or by visiting our website at www.molinahealthcare.com.

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.

ECHO® Survey

The Experience of Care and Health Outcomes (ECHO®) 3.0 Survey is an NCQA endorsed tool that assesses the experience, needs, and perceptions of Members with their behavioral health

care. Similar to CAHPS®, the ECHO® survey for adults produce the following measures of patient experience:

- Getting treatment quickly
- How well clinicians communicate
- Getting treatment and information from the plan
- Perceived improvement
- Information about treatment options
- Overall rating of counseling and treatment
- Overall rating of the health plan

The ECHO® Survey will be administered annually to selected Members by an NCQA-certified vendor.

Provider Satisfaction Survey

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

Effectiveness of Quality Improvement Initiatives

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

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

Quality Rating System

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

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

Quality ratings are calculated for each eligible QHP product using clinical quality and enrollee experience survey data. Based on results, CMS will calculate and produce quality performance ratings for each health plan on a 1- to 5- star rating scale.

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

- Clinical Effectiveness
- Patient Safety
- Prevention
- Access
- Doctor and Care
- Efficiency and Affordability
- Plan Service

Clinical, Behavioral Preventive Practice Guidelines

Practice guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The recommendations for care are suggested guides for making clinical decisions. Clinicians and patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

Molina has adopted the following clinical practice guidelines:

- Asthma
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Bipolar
- Chlamydia and Gonorrhea
- Colorectal Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Hyperlipidemia
- Judicious use of Antibiotics
- Obesity
- Prescribing Opioids for Pain
- Preventing Heart Attack and Death in Patients with Cardiovascular Disease
- Treatment of Substance Related Disorders in Children and Adolescents
- Treatment of Substance Related Disorders in Adults
- Preventive Health Guideline: Infants, Children, and Adolescents (children up to 24 months care for children 2 to 19 years of age, – 19 years old, includes Immunization.
- Preventive Health Guideline: Adults (20-64 years of age and 65 years and older, includes immunization)
- Preventive Health Guideline: Routine Prenatal Care

Additionally, to meet the EPSDT guidelines, Molina uses preventive health guidelines based on U.S. Preventive Services Task Force Recommendations.

To evaluate effectiveness, Molina measures performance against important aspects of each clinical practice and preventive guidelines using, but not limited to, the following:

- Emergency Room visit rates, if applicable

- Hospitalization Rates, if applicable
- HEDIS rates
- Member/family satisfaction with the program for those members receiving active care management.

Clinical, Behavioral, and Preventive Practice Guidelines can be reviewed from the Molina Healthcare website at the below links:
http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx
and
http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_prevent.aspx

If you would like a printed copy of this information, you may request it by calling our Quality Department at (800) 869-7175 Ext. 147181.

Health Management Programs

Molina Healthcare of Washington Health Management programs provide patient education information to Members and facilitate Provider access to these chronic disease programs and services. Health Management staff; Registered Nurse, Registered Dietitian, Social Worker, and or Health Educator are available telephonically to share information about Molina Programs. They will assist Members with preventative education and management of their conditions. He/she will collaborate with the Member and Provider relating to specific needs identified for best practices. Molina requests that you as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. These include programs, such as:

- Asthma
- Depression

For more info about our programs, please call:

- Healthcare Services (HCS) at (800) 869-7165)
- TTY/TDD at 711 Relay
- Visit www.molinahealthcare.com

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 CMS accepted diagnosis or procedure code;

- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- 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

Provider Participation

Contracted Providers are automatically notified whenever their patients are enrolled in a health management program. Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Patient education resources;
- Provider Newsletters promoting the health management programs, including 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 HCS Department toll free at (800) 869-7165.

Weight Management

Given the diversity of Molina Healthcare's membership, a 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.

Program Overview

Molina's Weight Management program is comprised of one-on-one telephonic education and coaching by a case manager to support the weight management needs of the Member. The Health Education staff work closely with the Member, providing education on nutrition, assessing the Member's readiness to lose weight, and supporting the Member throughout their participation in the Weight Management Program.

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 (i.e. Healthwise Knowledgebase). 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:

- Counsel on the health benefits of weight loss.
    - One-on-one telephonic counseling
    - BMI Identification
    - Provider and community resource referral, *if available in the Member's area*
- 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
- Teach Behavior Modification techniques
    - Promote healthy lifestyle changes
    - Monitor eating behavior
    - Rewarding oneself for healthy changes and progress
- 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, *if available in the Member's area*
    - Actively involve practitioners, Members, families, and other care providers in the planning, implementation, and evaluation of care.

Program Eligibility Criteria and Referral Source

Molina's Weight Management program is designed for adults who are eligible Molina Healthcare Members, 18 years of age or older upon enrollment in the program and are not actively being case managed. The proposed program model is an "invitational" design with the Member agreeing to participate in the program.

Multiple sources are used to identify potential participants. These include the following:

- Member Services – welcome calls made by staff to new Member households and incoming calls have the potential to identify eligible Members.
- Practitioner referral
- Case Management or Utilization Management review for an eligible Member who not actively being case managed.
- Member self-referral – general plan promotion of program through Member newsletter and other Member communications
- Nurse Advice Line services and other sources of Member/Provider contact whereby identification and referral is possible

To find out more information about the health management programs, please HCS Department toll free at (800) 869-7165.

Smoking Cessation

Molina Healthcare offers smoking cessation to all Washington Medicaid Members over the age of 18 as well as pregnant women under the age of 18 through the Quit-4-Life program at (866) 891-2320.

To know which pharmaceutical smoking cessation products and aids are available on Molina's formulary or if you would like to request approval for a product not currently on formulary, please call our pharmacy department at (800) 213-5525.

Transitions of Care (ToC)

- The Molina Healthcare TOC Program is designed to manage member transitions between levels of care to improve quality of care for members, ensure follow-care needs are met, and prevent return to higher levels of care. The program interventions include: improving member and practitioner understanding of roles, expectations and goals; ensure the member is prepared to continue the plan of care from one setting to another; coordinate needed services with appropriate practitioners or community resources; and promote member self-management while encouraging empowerment.

- Goals of the program also include preventing avoidable hospital readmission and emergency room visits, optimal transitioning from one care setting to another and/or identifying an unexpected change in condition requiring further assessment and intervention and confirming/reestablishing the member's connection to their medical home.

- Transition services are provided telephonically or in-person depending on the level of risk of readmission. Readmission risk is assessed initially by the Inpatient Review team of nurses who manage members' admissions from admission notification to discharge. Members are contacted by a ToC coach by phone or in-person while in the facility if possible to assist with coordinating health care needs prior to discharge, then post-discharge by phone or in the member's residence to ensure a smooth transition.

For more information about this program, please call Member Services at (800) 869-7165.

Asthma Program

- Asthma Clinical Practice - These guidelines can be reviewed from the Molina Healthcare website at http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx

- Asthma Newsletters – Molina Healthcare distributes asthma newsletters to identified Members. You can receive a copy by calling our Quality Improvement Health Education Line at (800) 423-9899, Ext. 141428 or by going to http://www.molinahealthcare.com/members/wa/en-US/mem/medicaid/overvw/resources/news/Pages/mngtnews.aspx

- Smoking Cessation – Molina Healthcare offers smoking cessation to all Washington Medicaid Members over the age of 18 through the Quit-4-Life program at (866) 784-8454.

- Members can obtain additional information on Asthma on Molina Healthcare's Staying Healthy Webpage: http://www.molinahealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

Healthy Living with Diabetes

Molina Healthcare has a diabetes health management program called *Healthy Living with Diabetes* designed to assist Members in understanding diabetes and self-care.

The *Healthy Living with Diabetes* program includes:

- Diabetes Clinical Practice Guidelines These guidelines can be reviewed from the Molina Healthcare website at http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx

- Diabetes Newsletters – Molina Healthcare distributes newsletters to diabetic Members. You can receive a copy by calling our Health Education Line at (800) 423-9899, Ext. 141428 or by going to http://www.molinahealthcare.com/members/wa/en-US/mem/medicaid/overvw/resources/news/Pages/mngtnews.aspx

- Diabetes Education – Diabetes education is covered for all Molina Healthcare Members. We encourage Providers to refer patients to these services, especially for newly diagnosed diabetics or those having difficulty managing their disease.

- Smoking Cessation – Molina Healthcare offers smoking cessation to all Washington Medicaid Members over the age of 18 through the Quit-4-Life program at (866) 784-8454.

- Members can obtain additional information on Diabetes on Molina Healthcare's Staying Healthy Webpage: http://www.molinahealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

Heart Healthy Living Cardiovascular program

Molina Healthcare has a Cardiovascular Health Management Program called *Heart Healthy Living* aimed at assisting Members with their understanding and management of cardiovascular disease (CVD). We have focused on five specific areas:

- Hyperlipidemia
- Congestive Heart Failure
- Hypertension
- Myocardial Infarction
- Angina

Molina Healthcare believes excellent care starts in your office. Our role is to provide additional services to complement your care.

The *Heart Healthy Living program* includes:

- Cardiovascular Disease Clinical Practice Guidelines These guidelines can be reviewed from the Molina Healthcare website at http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx
- Smoking Cessation – Molina Healthcare offers smoking cessation to all Washington Medicaid Members over the age of 18 through the Quit-4-Life program at (866) 784-8454. We encourage providers to use this service.
- Members can obtain additional information on Cardiovascular Disease on Molina's Staying Healthy webpage: http://www.molinahealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

Chronic Obstructive Pulmonary Disease program (COPD)

Molina Healthcare has a Chronic Obstructive Pulmonary Disease (COPD) Health Management Program aimed at assisting Members with their understanding and management of COPD. Molina Healthcare believes excellent care starts in your office. Our role is to provide additional services to complement your care.

COPD program includes:

- COPD Clinical Practice Guidelines These guidelines can be reviewed from the Molina Healthcare website at http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx
- Smoking Cessation – Molina Healthcare offers smoking cessation to all Washington Medicaid Members over the age of 18 through the Quit-4-Life program at (866) 784-8454. We encourage providers to use this service.
- Members can obtain additional information on COPD on Molina's Staying Healthy webpage: http://www.molinahealthcare.com/members/common/en-US/healthy/hlthcondcare/Pages/carehealth.aspx

Enrollees with Special Healthcare Needs

Molina Healthcare is working toward improving care and service for Enrollees with Special Health Care Needs. Molina Healthcare in collaboration with its providers assist enrollees and families with coordination of care and to provide information regarding available resources.

Special health care needs may include but are not limited to:

- Those who have or are at increased risk of serious and/or chronic physical, developmental, behavioral or emotional conditions, substance use disorder
- Require health and related services of a type or amount beyond what is generally necessary
- Inappropriate (over and under) utilization of services including prescription use
- Specific diagnoses of children with special health care needs include: asthma, diabetes, heart disease, obesity, cancer, autism, cerebral palsy, Down's syndrome, cleft lip and/or palate, attention deficit hyperactivity disorder, prematurity, speech/language delay, sickle cell anemia, diabetes, arthritis, blindness, hearing loss, gross and/or fine motor delay and multiple sclerosis.

Providers who are caring for enrollees with Special Health Care Needs are required to develop an individualized treatment plan and coordinate care with clinical and non-clinical services, such as community resources.

The treatment plan should include the following:

- Short and long term goals
- Enrollee participation
- Modified based on enrollee's changing needs
- Barriers and how they were addressed

Case Management services are available for those Enrollees with Special Health Care Needs. Refer to Section 6, Medical Management.

Clinical, Behavioral, Preventive, Evidence-Based Practice Guidelines

Practice guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The recommendations for care are suggested guides for making clinical decisions. Clinicians and patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

Molina has adopted the following clinical practice guidelines:

- Asthma
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Bipolar
- Chlamydia and Gonorrhea
- Colorectal Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes

- Heart Failure
- Hypertension
- Hyperlipidemia
- Judicious use of Antibiotics
- Obesity
- Prescribing Opioids for Pain
- Preventing Heart Attack and Death in Patients with Cardiovascular Disease
- Treatment of Substance Related Disorders in Children and Adolescents
- Treatment of Substance Related Disorders in Adults
- Preventive Health Guideline: Infants, Children, and Adolescents (children up to 24 months care for children 2 to 19 years of age, – 19 years old, includes Immunization.
- Preventive Health Guideline: Adults (20-64 years of age and 65 years and older, includes immunization)
- Preventive Health Guideline: Routine Prenatal Care

Additionally, to meet the EPSDT guidelines, Molina uses preventive health guidelines based on U.S. Preventive Services Task Force Recommendations.

To evaluate effectiveness, Molina measures performance against important aspects of each clinical practice and preventive guidelines using, but not limited to, the following:

- Emergency Room visit rates, if applicable
- Hospitalization Rates, if applicable
- HEDIS rates
- Member/family satisfaction with the program for those members receiving active care management.

Clinical, Behavioral, and Preventive Practice Guidelines can be reviewed from the Molina Healthcare website at the below links:
http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_clinical.aspx
and
http://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/guide_prevent.aspx

If you would like a printed copy of this information, you may request it by calling our Quality Department at (800) 869-7175 Ext. 147181.

CLAIMS and COMPENSATION

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:

- National Provider Identifier (NPI) HCA Enrollment Requirements
- Hospital Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Timely Claim Filing

- Claim Edit Process
- Clam Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Remittance Advice and Electronic Funds Transfer
- Claim Corrections
- Overpayment and Incorrect Payment
- Claim Adjustment Disputes/Reprocessing
- Billing the Member
- Fraud and Abuse
- Encounter Data

Molina Healthcare generally follows HCA guidelines for claims processing and payment for the Apple Health (AH), Integrated Managed Care (IMC) and Behavioral Health Services Only (BHSO) Medicaid programs. These guidelines are contained in the HCA Medicaid Provider Guides. The complete guide and information on ordering a printed copy can be found at http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides.

National Provider Identifier (NPI) HCA Billing and Non-Billing Enrollment Requirements

Per federal regulation (42.C.F.R. 455.410(b)) providers who have a contract with the state's Medicaid agency or a contract with a Managed Care Organization (MCO) that serve Medicaid Clients must enroll with HCA under a Non billing or Billing agreement. The provider's National Provider Identifier (NPI) submitted on all claims must be the NPI registered with HCA.

Effective January 1, 2018, Molina Healthcare will deny/reject all claims submitted to Molina for processing if billed with an NPI that is not enrolled with HCA or does not match what HCA identifies as the enrolled NPI number.

For additional information and to access the Non-Billing and Billing and servicing enrollment form, which must be used to register with HCA or to correct an NPI, visit the HCA website at http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-non-billing-individual-provider.

Hospital Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably been prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).
The following is a list of CMS Hospital Acquired Conditions. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility

4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries
    e) Burn
    f) Other Injuries
6) Manifestations of Poor Glycemic Control
    a) Hypoglycemic Coma
    b) Diabetic Ketoacidosis
    c) Non-Ketotic Hyperosmolar Coma
    d) Secondary Diabetes with Ketoacidosis
    e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10) Surgical Site Infection Following Certain Orthopedic Procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a) Laparoscopic Gastric Restrictive Surgery
    b) Laparoscopic Gastric Bypass
    c) Gastroenterostomy
12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13) Iatrogenic Pneumothorax with Venous Catheterization
14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement

What this means to Providers:

- Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: http://www.cms.hhs.gov/HospitalAcqCond/

Claim Submission

Providers are required to submit Claims to Molina Healthcare with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or Molina's Provider WebPortal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims) and use electronic Payer ID number: 38336**.** For Members assigned to a delegated

medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card or refer to Section 14 of this Provider Manual, Delegation -Medical Group-IPA Operations.
Claims that do not comply with Molina's electronic Claim submission requirements will be denied.

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

Required Elements:
The following information must be included on every claim:

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

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim; and any paper claim submissions will be denied.

National Provider Identifier (NPI)

A valid NPI which is enrolled with HCA as a billing or non-billing NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina Healthcare as well as HCA or claims may be denied.

Electronic Claim Submissions

Molina requires Participating Providers to submit Claims electronically. Electronic Claims submission provides significant benefits to the Provider including:

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare via the secure Provider Portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 38336

Provider Portal

Molina's secure Provider Portal offers a number of claims processing functionalities and benefits:

Available to all Providers at no cost
Available 24 hours per day, 7 days per week
Ability to add attachments to claims through the Portal
Submit corrected claims
Easily and quickly void claims
Check claim status
Receive timely notification of a change in status for a particular claim
Submit COB Claims

Clearinghouse

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

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

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the claims from your clearinghouse
- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve the issue. If the Provider's clearinghouse is unable to resolve, the Provider may call the Molina EDI Customer Service line at (866) 409-2935 or email us at EDI.Claims@molinahealthcare.com for additional support.

Paper Claim Submissions

Paper claims are not accepted by Molina. Claims submitted via paper may be denied and you will need to resubmit your claim electronically for processing.

Coordination of benefits (COB) and Third Party Liability

Medicaid is the payer of last resort. Private and government carriers must be billed prior to billing Molina Healthcare or Medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn if the Member has health insurance, benefits or Covered Services other than

from Molina Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina Healthcare of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the claim submission. Providers can submit claims with attachments, including EOBs and other required documents by utilizing Molina's secure Provider Portal. You may also submit COB claims via the clearing house by populating the appropriate segments with the primary payment information.

There are four exceptions for which Molina Healthcare does not require an EOB from the primary insurance:

- Medicare is primary and the service being billed is a non-covered service by Medicare
- The primary carrier has no available provider within a 25 mile radius of the members address. If claims are denied for this reason the provider may contact Provider Services to request the claim be processed for payment
- The primary insurance only covers emergency services or offers limited benefits. Molina will contact the primary carrier to validate and update our systems to reflect Molina as the primary carrier
- The member is American Indian / Alaskan Native (AI/AN)

When COB payment is as much as or more than Molina Healthcare's allowable rate and there is no patient responsibility from the primary insurance the claim has been paid in full. Molina Healthcare will make no additional payment.

When COB payment is as much as or less than Molina Healthcare's allowable rate with patient responsibility from the primary insurance, Molina Healthcare reimburses the patient responsibility not to exceed Molina Healthcare's allowable rate.

Molina Healthcare may request a refund for COB claims paid in error up to 30 months from the original paid date.

Molina Healthcare is required to notify HCA monthly when a Member is verified to have health coverage with any other health carrier, including Dual Coverage. HCA provides COB information to Molina Healthcare on a regular basis through daily enrollment files. If HCA determines the Member has Dual Coverage with Medicare, the Member will be prospectively dis-enrolled from AH and enrolled in fee-for-service Medicaid.

Third Party Liability

Molina Healthcare is the payer of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare may deny Claims when Third Party has been established and will process Claims for Covered Services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a Claim. Molina Healthcare will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a format acceptable to and approved by Molina, and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies or procedures. Claims must be submitted by the Provider to Molina no later than the limitation stated in the provider contract or within 180 calendar days after discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within 180 calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines

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

Molina utilizes a claims adjudication system that encompasses edits and audits that follow Washington Federal requirements and also administers payment rules based on generally accepted principles of correct coding. Payment rules based on generally accepted principles of correct coding include, but are not limited to, the following:

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

Coding Sources

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

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

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

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

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

Claim Auditing

Provider acknowledges Molina's right to conduct post-payment billing audits. Provider shall cooperate with Molina's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data. Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P. **Claims submitted without the correct coding will be returned to the Provider for resubmission.**

EDI (Clearinghouse) Submission:

837P

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
    - "1"-ORIGINAL (initial claim)
    - "7"–REPLACEMENT (replacement of prior claim)
    - "8"-VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF segment (claim information) must include the original claim number of the claim being corrected, found on the remittance advice.

837I

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

Requests for correction of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim. See Section 14 for additional information on delegated medical group/IPA's.

Timely Claim Processing

Claims processing will be completed for contracted providers in accordance with the timeliness provisions set forth in the provider's contract. Unless the provider and Molina or contracted medical group/IPA have agreed in writing to an alternate payment schedule, Molina will process the claim for services within the minimum standards as set forth by the Office of the Insurance Commissioner (OIC) and HCA:

- Ninety-five (95%) percent of the monthly volume of "clean" claims will be adjudicated within 30 calendar days of receipt by Molina Healthcare. A "clean" claim has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.
- Ninety-five (95%) percent of the monthly volume of claims shall be paid or denied within 60 calendar days of receipt by Molina Healthcare.
- Ninety-nine (99%) percent of all claims shall be paid or denied within 90 calendar days of receipt by Molina Healthcare.

The receipt date of a claim is the date Molina Healthcare receives notice of the claim.

Electronic Remittance Advice and Electronic Funds Transfer

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow providers to reduce paperwork, provides searchable ERAs, and providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the provider for EFT enrollment, and providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery.

To register please go to https://providernet.adminisource.com. If you have any questions regarding the registration process, please contact FIS/ProviderNet at (877) 389-1160 or email Provider.Services@fisglobal.com.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a claim for such Overpayment.

Molina may request a refund for overpayments or incorrect payments on services provided within 24 months and 30 months for COB claims from the date of the original remittance advice. If a provider does not repay or dispute the overpaid amount within 45 days of the request, Molina may offset the payment amount(s) against future payments made to the provider.

If you prefer Molina offset payment on a future Remittance Advice for overpaid or incorrectly paid claims, please fax a Molina Early Reversal Permission Form to the Claims Recovery Department at (888) 396-1520.

If you have any questions regarding a refund request letter, please call the Claims Recovery Department at (866) 642-8999.

In the event the provider receives a check that is not theirs or finds an overpayment, please send the refund with a copy of the remittance advice and claim information to:

Molina Healthcare of Washington, Inc.
PO Box 30717
Los Angeles, CA 90030-0717

Billing the Member

Molina Healthcare contracted providers cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party.

In accordance with WAC 182-502-0160, a contracted provider may only bill fee-for-service or managed care clients for covered health care services, if the Member and the provider both sign Health Care Authority form 13-879 "Agreement to Pay for Healthcare Services" no more than 90 days prior to services being rendered. The form must be completed in full. For Members with limited English proficiency, form 13-879 must be translated into the Member's primary language. If necessary, this form must also be interpreted for the Member. If the agreement is interpreted, the interpreter must also sign it. All other requirements for form 13-879 apply.

Providers must accept payment by Molina Healthcare as payment in full in accordance with 42 CFR 447.15. Balance billing is not permitted. For additional information, refer to WAC 182-502-0160 and HCA Memo #10-25.

Fraud and Abuse

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

Encounter Data

Each capitated Provider/organization delegated for Claims processing is required to submit Encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as

regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least once per month, and within your contracts timely claims filing requirements in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D - Dental. Data must be submitted with Claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina should be reported.

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

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

Please see Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers on our website at http://www.molinahealthcare.com/providers/common/duals/ediera/PDF/edi_comm_molina_companion_guide_5010.pdf .

When your Encounters are filed electronically you should receive:

- For any direct submission to Molina you should receive a 999 acknowledgement of your transmission
- For Encounter submission you will also receive a 277CA response file for each transaction

CREDENITALING AND RECREDENTIALING

The purpose of the Credentialing program is to strive to assure that the Molina Healthcare network consists of quality 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 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 the standards of the National Committee of Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Definitions

A Rental/Leased Network - a network of Providers that leases its panel to another network or insurer with an emphasis on expanding Provider access and negotiating discounted fee-for-service fees. This type of network is sometimes referred to as a brokerage-leased network or thought of as "wholesale," since Members' access to the network is through an intermediary.

Primary Care Provider (PCP) – a Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to Pediatricians, Family Providers, General Providers or Internists, as designated by Molina.

General Practitioner – Physicians who are not Board Certified and have not completed a training program from an accredited training program in their requested specialty.

Urgent Care Provider (UCP) - a Provider who is not a PCP and only provides urgent care services to Members. Urgent care services are medically necessary services, which are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours. A UCP may include PA, NP, MD and DO. The UCP is usually trained in general practice, internal medicine, family medicine, pediatrics, or emergency medicine. Some UCPs may also have specialty training.

Primary Source verification - the process by which Molina verifies credentialing information directly from the entity that originally conferred or issued the credential to the Provider.

Locum Tenens – a substitute physician used to fill in for a regular physician for reasons such as illness, pregnancy, vacation, or continuing medical education. The regular physician bills and receives payment for the substitute physician as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee.

Physician – is a Doctor of Medicine (MD) or Doctor of Osteopathy (DO)

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.

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 Providers 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 Providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina. Molina. These criteria and the sources used to verify these criteria are listed in the table below.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Providers 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 Provider to a hearing or any other rights of review.

Providers must meet the following criteria to be eligible to participate in the Molina Healthcare network. If the Provider fails to meet/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. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Application Provider must submit to Molina a complete, signed and dated credentialing application. The application must be typewritten or completed in non-erasable ink. Application must include all required attachments. The Provider must sign and date the application attesting their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. **If the Provider's attestation exceeds one-hundred-eighty (180) days before the credentialing decision, the Provider 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 Provider to update the attestation.** If Molina or the	▪ Every section of the application is complete or designated N/A ▪ Every question is answered ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision ▪ All required attachments are present ▪ Every professional question is clearly answered and the page is completely legible ▪ A detailed written response is included for every yes answer on the professional questions	All Provider types	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Credentialing Committee requests any additional information or clarification, the Provider must supply that information in the period requested. Any changes made to the application must be initialed and dated by the Provider. Whiteout may not be used on the application rather the incorrect information must have a line drawn through it with the correct information written/typed and must be initiated and dated by the Provider. 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 does not consider the associated attestation elements as present if the Provider did not attest to the application within the required period of one-hundred-eighty (180) days. If State regulations require Molina to use a credentialing application that does not contain an attestation, Molina must attach an addendum to the application for attestation. The application and/or attestation documents cannot be altered or				

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
modified.				
License, Certification or Registration Provider must hold an active, current valid license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. If a Provider has ever had his or her professional license/certification/registration in any State suspended or revoked or Provider has ever surrendered, voluntarily or involuntarily, his or her professional license/certification/registration in any State while under or to avoid investigation by the State or due to findings by the State resulting from the Provider's acts, omissions or conduct, Molina will verify all licenses, certifications and registrations in every State where the Provider has practiced.	Verified directly with the appropriate State licensing or certification agency. This verification is conducted by one of the following methods: ▪ On-line directly with licensing board ▪ Confirmation directly from the appropriate State agency. The verification must indicate: ▪ The scope/type of license ▪ The date of original licensure ▪ Expiration date ▪ Status of license ▪ If there have been, or currently are, any disciplinary action or sanctions on the license.	All Provider types who are required to hold a license, certification or registration to practice in their State	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
DEA or CDS certificate Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members.	DEA or CDS is verified by one of the following: ▪ On-line directly with the National Technical Information Service (NTIS) database. ▪ On-line directly with the U.S. Department of Justice Drug Enforcement Administration,	Physicians, Oral Surgeons, Nurse Providers, Physician Assistants, Podiatrists	Must be in effect at the time of decision and verified within one-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
If a Provider has a pending DEA/CDS certificate because of just starting practice or because of moving to a new State, the Provider may be credentialed on "watch" status provided that Molina has a written prescription plan from the Provider. This plan must describe the process for allowing another Provider with a valid DEA/CDS certificate to write all prescriptions requiring a DEA/CDS number. If a Provider has never had any disciplinary action taken related to his/her DEA or CDS and chooses not to have a DEA or CDS certificate, the Provider may be considered for network participation if they submit a prescription plan for another Provider with a valid DEA or CDS certificate to write all prescriptions. If a Provider does not have a DEA because it has been revoked, restricted or relinquished due to disciplinary reasons, the Provider is not eligible to participate in the Molina network.	Office of Diversion Control ▪ Current, legible copy of DEA or CDS certificate ▪ On-line directly with the State pharmaceutical licensing agency, where applicable Written prescription plans: ▪ A written prescription plan must be received from the Provider. It must indicate another Provider with a valid DEA or CDS certificate to write all prescriptions requiring a DEA number. ▪ Molina must primary source verify the covering Providers DEA.			
Education & Training Providers will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore, Providers	As outlined below under Education, Residency, Fellowship and Board Certification.	All Provider Types	Prior to credentialing decision	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
must confine their practice to their credentialed area of practice when providing services to Molina Members.				
Education Provider must have graduated from an accredited school with a degree required to practice in their specialty.	The highest level of education is primary source verified by one of the following methods: ▪ Primary source verification of Board Certification as outlined in the Board Certification section of this policy. ▪ Confirmation from the State licensing agency when Molina has documentation that the State agency conducts primary source verification of the highest level of education and this confirmation is not greater than 12-months old. ▪ The American Medical Association (AMA) Physician Master File. This verification must indicate the education has specifically been verified. ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must	All Provider types	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	indicate the education has specifically been verified. ▪ Confirmation directly from the accredited school. This verification must include the type of education, the date started, date completed and if the Provider graduated from the program. ▪ Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. ▪ Association of schools of the health professionals, if the association performs primary-source verification of graduation from medical school and Molina has written confirmation from the association that it performs primary source verification of graduation and this confirmation is not greater than twelve (12) months old. ▪ If a physician has completed education and training through the AMA's Fifth Pathway program, this must be			

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	verified through the AMA. ▪ Confirmation directly from the National Student Clearing House. This verification must include the name of the accredited school, type of education and dates of attendance.			
Residency Training Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Verification of the residency is always required except for General Providers as described in the General Provider section below. Molina only recognizes residency programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must have completed a training program in Oral and Maxillofacial Surgery accredited by	Residency Training is primary source verified by one of the following methods: ▪ Primary source verification of current or expired board certification in the same specialty of the Residency Training program (as outlined in the Board Certification section of this policy). ▪ The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been verified. ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the training has specifically been verified.	Oral Surgeons, Physicians, Podiatrists	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program.	▪ Confirmation directly from the accredited training program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed. ▪ Association of schools of the health professionals, if the association performs primary-source verification of residency training and Molina has written confirmation from the association that it performs primary source verification of graduation and this confirmation is not greater than twelve (12) months old. ▪ For Closed Residency Programs, residency completion can be verified through the Federation of State Medical Boards Federation Credentials Verification Service (FCVS). ▪ For podiatrists, confirmation directly from the Council of Podiatric Medical Education			

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	(CPME) verifying podiatry residency program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed.			
Fellowship Training If the Provider is not board certified in the specialty in which they practice and has not completed a residency program they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing. When a Provider has completed a Fellowship, Molina always completes either a verification of Board Certification or Verification of Residency in addition to the verification of Fellowship to meet the NCQA requirement of verification of highest level of training.	Fellowship Training is primary source verified by one of the following methods: ▪ Primary source verification of current or expired Board Certification in the same specialty of the Fellowship Training program (as outlined in the Board Certification section of this policy). ▪ The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been verified. ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the training has specifically been verified.	Physicians	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	▪ Confirmation directly from the accredited training program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed.			
Board Certification Board certification in the specialty in which the Provider is practicing is preferred but not required. Initial applicants who are not board certified may be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards: ▪ American Board of Medical Specialties (ABMS) ▪ American Osteopathic Association (AOA) ▪ American Board of Foot and Ankle Surgery (ABFAS) ▪ American Board of Podiatric Medicine (ABPM) ▪ American Board of Oral and Maxillofacial Surgery ▪ American Board of Addiction Medicine	Board certification is primary source verified through one of the following: ▪ An official ABMS (American Board of Medical Specialties) display agent, where a dated certificate of primary-source authenticity has been provided (as applicable). ▪ AMA Physician Master File profile (as applicable). ▪ AOA Official Osteopathic Physician Profile Report or AOA Physician Master File (as applicable). ▪ Confirmation directly from the board. This verification must include the specialty of the certification(s), the original certification date, and the expiration date. ▪ On-line directly from the American	Dentists, Oral Surgeons, Physicians, Podiatrists	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
(ABAM) Molina must document the expiration date of the board certification within the credentialing file. If the board certification does not expire, Molina must verify a lifetime certification status and document in the credentialing file. American Board of Medical Specialties Maintenance of Certification Programs (MOC) –Board certified Providers that fall under the certification standards specified that board certification is contingent upon meeting the ongoing requirements of MOC, no longer list specific end dates to board certification. Molina will list the certification as active without an expiration date and add the document in the credentialing file.	Board of Podiatric Surgery (ABPS) verification website (as applicable). ▪ On-line directly from the American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM) website (as applicable). ▪ On-line directly from the American Board of Oral and Maxillofacial Surgery website www.aboms.org (as applicable). ▪ On-line directly from the American Board of Addiction Medicine website https://www.abam.net/find-a-doctor/ (as applicable).			
General Practitioner Providers who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a general Provider in the Molina network. To be eligible, the Provider must have maintained a primary care practice in good	The last five years of work history in a PCP/General practice must be included on the application or curriculum vitae and must include the beginning and ending month and year for each work experience. Any gaps exceeding six months will be reviewed and clarified either verbally or in writing.	Physicians	One-hundred-eighty (180) Calendar Days	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
standing for a minimum of the most recent five years without any gaps in work history. Molina will consider allowing a Provider who is/was board certified and/or residency trained to participate as a general Provider, if the Provider is applying to participate in one of the following specialties : ▪ Primary Care Physician ▪ Urgent Care ▪ Wound Care	Verbal communication will be appropriately documented in the credentialing file. A gap in work history that exceeds 1 year will be clarified in writing directly from the Provider.			
Advanced Practice Nurse Providers Advanced Practice Nurse Providers must be board certified or eligible to become board certified in the specialty in which they are requesting to practice. Molina recognizes Board Certification only from the following Boards: ▪ American Nurses Credentialing Center (ANCC) ▪ American Academy of Nurse Providers Certification Program (AANP) ▪ Pediatric Nursing Certification Board (PNCB) ▪ National Certification Corporation (NCC)	Board certification is verified through one of the following: ▪ Confirmation directly from the board. This verification must include the specialty/scope of the certification(s), the original certification date, and the expiration date. ▪ Current copy of the board certification certificate including the specialty/scope of the certifications(s), the original certification date and the expiration date ▪ On-line directly with licensing board, if the licensing primary verifies a Molina recognized board certification. License must indicate board	Nurse Providers	One-hundred-eighty (180) Calendar Days	Initial and Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	certification/scope of practice. ▪ Provider attests on their application to board certification including the specialty/scope of the certifications(s), the original certification date and the expiration date.			
Physician Assistants Physician Assistants must be licensed as a Certified Physician Assistant. Physician Assistants must also be currently board certified or eligible to become board certified the National Commission on Certification of Physician Assistants (NCPPA).	Board certification is primary source verified through the following: ▪ On-line directly from the National Commission on Certification of Physician Assistants (NCPPA) website https://www.nccpa.net/.	Physician Assistants	One-hundred-eighty (180) Calendar Days	Initial and Recredentialing
Providers Not Able To Practice Independently In certain circumstances, Molina may credential a Provider who is not licensed to practice independently. In these instances it would also be required that the Provider providing the supervision and/or oversight be contracted and credentialed with Molina. Some examples of these types of Providers include: ▪ Physician Assistants ▪ Nurse Providers	▪ Confirm from Molina's systems that the Provider providing supervision and/or oversight has been credentialed and contracted.	Nurse Providers, Physician Assistants and other Providers not able to practice independently according to State law	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Work History Provider must supply a minimum of 5-years of relevant work history on the application or	The credentialing application or curriculum vitae must include at least 5-years of work history	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
curriculum vitae. Relevant work history includes work as a health professional. If the Provider has practiced fewer than 5-years from the date of Credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse Provider, clinical social worker) within the 5 years should be included. If Molina determines there is a gap in work history exceeding six-months, the Provider must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file. If Molina determines there is a gap in work history that exceeds one-year, the Provider must clarify the gap in writing.	and must include the beginning and ending month and year for each position in the Provider's employment experience. If a Provider has had continuous employment for five years or more, then there is no gap and no need to provide the month and year; providing the year meets the intent. Molina documents review of work history by including an electronic signature or initials of the employee who reviewed the work history and the date of review on the credentialing checklist or on any of the work history documentation.			
Malpractice History Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims and settlement history is requested from the Provider on the	▪ National Provider Data Bank (NPDB) report	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.				
State Sanctions, Restrictions on licensure or limitations on scope of practice Provider must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Provider must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. Molina will also verify all licenses, certifications and registrations in every State where the Provider has practiced. At the time of initial	▪ Provider must answer the related questions on the credentialing application. ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ The appropriate State/Federal agencies are queried directly for every Provider and if there are any sanctions, restrictions or limitations, complete documentation regarding the action will be requested. ▪ The NPDB is queried for every Provider.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
application, the Provider 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.				
Medicare, Medicaid and other Sanctions Provider must not be currently sanctioned, excluded, expelled or suspended from any State or federally funded program including but not limited to the Medicare or Medicaid programs. Provider must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. Provider must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving	▪ The HHS Inspector General, Office of Inspector General (OIG) is queried for every Provider. ▪ Molina queries for State Medicaid sanctions/exclusions/terminations through each State's specific Program Integrity Unit (or equivalent). In certain circumstances where the State does not provide means to verify this information and Molina has no way to verify State Medicaid sanctions/exclusions/terminations. ▪ The System for Award Management (SAM) system is queried for every Provider. ▪ The NPDB is queried for every	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

[1] If a Provider's application is denied solely because a Provider 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 Provider may reapply as soon as Provider 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 (1) year from the date of original denial.

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.	Provider.			
Professional Liability Insurance Provider must have and maintain professional malpractice liability insurance with limits that meet Molina criteria as stated below unless otherwise stated in addendum B. This coverage shall extend to Molina Members and the Providers activities on Molina's behalf. **The required limits are as follows:** **Physician (MD,DO) Nurse Provider, Certified Nurse Midwife, Oral Surgeon, Physician Assistant, Podiatrist =** $1,000,000/$3,000,000 **All non-physician Behavioral Health Providers, Naturopaths, Optometrists =** $1,000,000/$1,000,000 **Acupuncture, Chiropractor, Massage Therapy, Occupational Therapy, Physical Therapy, Speech Language Pathology =**	A copy of the insurance certificate showing: ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional liability or medical malpractice insurance ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage ▪ Either the specific Provider name or the name of the group in which the Provider works ▪ Certificate must be legible Current Provider application attesting to current insurance coverage. The application must include the following: ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional liability	All Provider types	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
$200,000/$600,000	or medical malpractice insurance ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage Providers maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance. A copy of the Federal tort or self-insured letter or an attestation from the Provider showing active coverage are acceptable. Confirmation directly from the insurance carrier verifying the following: ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional liability or medical malpractice insurance ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage			
Inability to Perform Provider must disclose any inability to perform essential functions of a Provider in their area of	▪ Provider must answer all the related questions on the credentialing	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. An inquiry regarding inability to perform essential functions may vary. Molina may accept more general or extensive language to query Providers about impairments.	application. ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision			
Lack of Present Illegal Drug Use Provider must disclose if they are currently using any illegal drugs/substances. An inquiry regarding illegal drug use may vary. Providers may use language other than "drug" to attest they are not presently using illegal substances. Molina may accept more general or extensive language to query Providers about impairments; language does not have to refer exclusively to the present, or only to illegal substances. If a Provider discloses any issues with substance abuse (e.g. drugs, alcohol) the Provider must provide evidence of either actively and successfully	▪ Provider must answer all the related questions on the credentialing application. ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ If the Provider discloses they are currently participating in a substance abuse monitoring program, Molina will verify directly with the applicable substance abuse monitoring program to ensure the Provider is compliant in the program or has successfully completed the program.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
participating in a substance abuse monitoring program or successfully completing a program.	▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision			
Criminal Convictions Provider must disclose if they have ever had any criminal convictions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. Provider 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.	▪ Provider must answer the related questions on the credentialing application. If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ If there are any yes answers to these questions, and the crime is related to healthcare, a national criminal history check will be run on the Provider. ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Loss or Limitation of Clinical Privileges Provider must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Provider has had privileges. If there is an affirmative response to the related disclosure questions on the	▪ Provider must answer the related questions on the credentialing application. If there are any yes answers to these questions, a detailed written response must be submitted by the Provider.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
application, a detailed response is required from the Provider.	▪ The NPDB will be queried for all Providers. ▪ If the Provider has had disciplinary action related to clinical privileges in the last five (5) years, all hospitals where the Provider has ever had privileges will be queried for any information regarding the loss or limitation of their privileges.			
Hospital Privileges Providers must list all current hospital privileges on their credentialing application. If the Provider has current privileges, they must be in good standing. Providers may choose not to have clinical hospital privileges if they do not manage care in the inpatient setting.	The Provider's hospital privileges are verified by their attestation on the credentialing application stating the Provider has current hospital admitting privileges.	Physicians and Podiatrists	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Medicare Opt Out Providers currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.	CMS Medicare Opt Out is queried for every Provider. If a Provider opts out of Medicare, that Provider may not accept Federal reimbursement for a period of two (2) years and may not be contracted with Molina for any Medicare or Duals (Medicare/Medicaid) lines of business.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
NPI	▪ On-line directly	All Providers	One-	Initial &

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Provider must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).	with the National Plan & Provider Enumeration System (NPPES) database.		hundred-eighty (180) Calendar Days	Recredentialing
SSA Death Master File Providers must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File. If a Provider's Social Security number is listed on the SSA Death Master File database, Molina will send the Provider a conflicting information letter to confirm the Social Security number listed on the credentialing application was correct. If the Provider confirms the Social Security number listed on the SSA Death Master database is their number, the Provider will be administratively denied or terminated. Once the Provider's Social Security number has been removed from the SSA Death Master File database, the Provider can reapply for participation into the Molina network.	▪ On-line directly with the Social Security Administration Death Master File database.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Review of Performance Indicators Providers going through recredentialing must	Written documentation from the Molina Quality Department and other departments as	All Providers	One-hundred-eighty (180) Calendar Days	Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
have documented review of performance indicators collected through clinical quality monitoring process, the utilization management system, the grievance system, enrollee satisfaction surveys, and other quality indicators.	applicable will be included in all recredentialing files.			
Denials Providers denied by the Molina Credentialing Committee are not eligible to reapply until one (1) year after the date of denial by the Credentialing Committee. At the time of reapplication, Provider must meet all criteria for participation.	▪ Confirmation from Molina's systems that the Provider has not been denied by the Molina Credentialing Committee in the past 1-year.	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing
Terminations Providers terminated by the Molina Credentialing Committee or terminated from the Molina network for cause are not eligible to reapply until five years after the date of termination. At the time of reapplication, Provider must meet all criteria for participation.	▪ Confirm from Molina's systems that the Provider has not been terminated by the Molina Credentialing Committee or terminated from the Molina network for cause in the past 5-years.	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing
Administrative denials and terminations Providers denied or terminated administratively as described throughout this policy are eligible to reapply for participation anytime as long as the Provider meets all criteria for participation.	▪ Confirmation from Molina's systems if a Provider was denied or terminated from the Molina network, that the reason was administrative as described in this policy.	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing
Employees of	When a Provider is	All Providers	Not	Initial and

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Providers denied, terminated, under investigation or in the Fair Hearing Process Molina may determine, in its sole discretion, that a Provider is not eligible to apply for network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from network participation by Molina, who is currently in the Fair Hearing Process, or who is under investigation by Molina. Molina also may determine, in its sole discretion that a Provider cannot continue network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from network participation by Molina. For purposes of these criteria, a company is "owned" by a Provider when the Provider has at least five percent (5%) financial interest in the company, through shares or other means.	denied or terminated from network participation or who is under investigation by Molina, it will be verified if that Provider has any employees. That information will be reviewed by the Credentialing Committee and/or Medical Director and a determination will be made if they can continue participating in the network.		applicable	Recredentialing

Burden of Proof

The Provider 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 Provider 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 Provider 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. Providers who fail to provide this burden of proof do not have the right to submit an appeal.

Provider termination and reinstatement

If a Provider's contract is terminated and later it is determined to reinstate the Provider, the Provider must be initially credentialed prior to reinstatement if there is a break in service more than thirty (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 Provider's reentry into the network. Not all elements require re-verification; for example, graduation from medical school or residency completion does not change. If the contract termination was administrative only and not for cause, if the break in service is less than thirty (30) calendar days, the Provider can be reinstated without being initially credentialed.

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

Providers terminating with a delegate and contracting with Molina directly

Providers credentialed by a delegate who terminate their contract with the delegate and either have an existing contract with Molina or wish to contract with Molina directly must be credentialed by Molina within six (6) months of the Provider's termination with the delegate. If the Provider has a break in service more than thirty (30) calendar days, the Provider must be initially credentialed prior to reinstatement.

Credentialing Application

At the time of initial credentialing and recredentialing, the Provider must complete a credentialing application designed to provide Molina with information necessary to perform a comprehensive review of the Provider's credentials. The application must be completed in its entirety. The Provider must attest that their application is complete and correct within one hundred-eighty (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 may use another organization's application as long as it meets all the factors. Molina Healthcare will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. The application must include, unless state law requires otherwise:

- 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.

The Process for Making Credentialing Decisions

All Providers requesting participation with Molina must complete a credentialing application. To be eligible to submit an application, Providers must meet all the criteria outlined above in the section titled "Criteria for Participation in the Molina Healthcare Network". Providers requesting initial credentialing may not provide care to Molina Members until the credentialing process is complete and final decision is rendered.

Molina recredentials its Providers at least every thirty-six (36) months. Approximately six (6) months prior to the recredentialing due date, the Providers application will be downloaded from CAQH (or a similar NCQA© accepted online applications source), or a request will be sent to the Provider requesting completion of a recredentialing application.

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

- Submit a completed application within the requested timeframe
- Attest to the application within the last one-hundred-eighty (180) calendar days
- Provide Molina 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 will complete all the verifications as outlined in the Molina Credentialing Program Policy. In order for the application to be deemed complete, the Provider must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina 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 must be provided.

If the Provider 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 administrative termination from the Molina network. Providers 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 the established guidelines below. 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. The Medical Director has the right to request the Credentialing Committee review any credentials file. The Credentialing Committee has the right to request to review any credentials file.

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 Providers, 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 ninety percent (90%).
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina at pre-assessment.
- Agree to Molina's contract terms and conditions for credentialing delegates.
- Submit timely and complete reports to Molina as described in policy and procedure.
- Comply with all applicable Federal and State Laws.
- If the IPA or Provider Group sub-delegates 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 identity, age, sexual orientation or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the Provider specializes. This does not preclude Molina from including in its network Providers who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Notification of Discrepancies in Credentialing Information

Molina will notify the Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Provider. Examples include but are not limited to actions on a license, malpractice claims history or sanctions. 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. Please also refer to the section below titled 'Providers Right to Correct Erroneous Information'.

Notification of Credentialing Decisions

A letter is sent to every Provider 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 Provider's credentials files. Under no circumstance will notification letters be sent to the Providers later than sixty (60) calendar days from the decision.

Confidentiality and Immunity

Information regarding any Provider 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 this Policy and Procedure. 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 Provider'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 Provider's provision of patient care services.

By providing patient care services at Molina, a Provider:

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the 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;

2. Actions reducing, suspending, terminating or revoking a 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 Provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a 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 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 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 (3) 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.

Providers Rights during the Credentialing Process

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

The Provider must notify the Credentialing Department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Provider 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 Provider are documents which the Provider sent to Molina (e.g., the application, the license and a copy of the DEA certificate). Providers may not copy documents that include pieces of information that are confidential in nature, such as the Provider credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, State Licensing Board), and verification of hospital privileges letters.

Providers Right to Correct Erroneous Information

Providers have the right to correct erroneous information in their credentials file. Providers 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 Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Provider. 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 Provider will detail the information in question and will include instructions to the Provider indicating:

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina.
- In their response, the Provider must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The Provider's response must be sent to Molina Healthcare, Inc. Attention: Credentialing Director at PO Box 2470 Spokane WA 99210.

Upon receipt of notification from the Provider, Molina will document receipt of the information in the Provider's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Provider's credentials file. The Provider will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with Providers', the Credentialing Department will notify the Provider. The Provider 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 Provider does not respond within ten (10) calendar days, their application processing will be discontinued and network participation will be denied or terminated.

Providers Right to be Informed of Application Status

Providers have a right, upon request, to be informed of the status of their application. Providers 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 Provider 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 Provider 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 Provider 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 Providers are competent and qualified to provide continuous quality care to Molina Members. A Provider may not provide care to Molina Members until the credentialing process is complete and the final decision has been rendered.

The Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicant Providers and for making recommendations regarding their participation in the Molina network. 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 Providers, 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 Provider 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 Provider

network. The Credentialing Committee representation includes at least five Providers. These may include Providers from the following specialties:

- Behavioral Health
- Dentist
- 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 Providers may be invited to participate when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., 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 recommendations regarding applicant's participation in the Molina network.
- Conduct ongoing monitoring of those Providers approved to be monitored on a "watch status".
- Access clinical peer input when discussing standards of care for a particular type of Provider 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 Practitioner Providers

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

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/Person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its

Subcontractors certify that neither it nor its Member/Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions

Molina monitors Provider sanctions between recredentialing cycles for all Provider types and takes appropriate action against Providers 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 thirty (30) calendar days of its release, Molina reviews the report to identify if any Molina Provider is found with a sanction. If a Molina Provider is found to be sanctioned by the OIG the Provider's contract will be immediately terminated effective the same date the sanction was implemented.

Molina also monitors each State Medicaid sanctions/exclusions/terminations through each State's specific Program Integrity Unit (or equivalent). Molina reviews each States published report within thirty (30) days of its release to identify if any Molina Provider is found to be sanctioned/excluded/terminated from the State's Medicaid program. If a Molina Provider is found to be sanctioned/excluded/terminated, the Provider will be immediately terminated in every State where they are contracted with Molina and for eery line of business.

Sanctions or limitations on licensure

Molina monitors for sanctions or limitations against licensure between credentialing cycles for all network Providers. All sanction or limitation of license information discovered during the ongoing monitoring process will be maintained in the Provider credentialing file. All Providers 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 provider must provide all necessary information to complete the recredentialing process within the requested time-frames or the Provider will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a recommendation.

NPDB Continuous Query

Molina enrolls all network Providers with the National Practitioner Data Bank ("NPDB") Continuous Query service.

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

Member Complaints/Grievances

Each Molina Health Plan has a process in place to investigate Provider-specific complaints from Members upon their receipt. Molina evaluates both the specific complaint and the Provider's history of issues, if applicable. The history of complaints is evaluated for all Providers at least every six (6) months.

Adverse Events

Each Molina Health Plan has a process in place for monitoring Provider adverse events at least every six (6) months. An adverse event is an injury that occurs while a Member is receiving health care services from a Provider. Molina monitors for adverse events at least every six (6) months.

Medicare Opt-Out

Providers participating in Medicare must not be listed on the Medicare Opt-Out report. Molina reviews the Opt-Out reports released from the appropriate Medicare financial intermediary showing all of the providers who have chosen to Opt-Out of Medicare. These reports are reviewed within thirty (30) calendar days of their release. If a Provider opts out of Medicare, that Provider may not accept Federal reimbursement for a period of two (2) years. These Provider contracts will be immediately terminated for the Molina Medicare line of business.

Social Security Administration (SSA) Death Master File

Molina screens Provider names against the SSA Death Master File database during initial and recredentialing to ensure Provider are not fraudulently billing under a deceased person's social security number. The names are also screened on a monthly basis to ensure there are no matches on the SSA Death Master File between credentialing cycles. If Molina identifies an exact match, the Provider will be immediately terminated for all lines of business effective the deceased date listed on the SSA Death Master File database.

System for Award Management (SAM)

Molina monitors the SAM once per month to ensure Providers have not been sanctioned. If a Molina Provider is found with a sanction, the Provider's contract is terminated effective the same date the sanction was implemented.

Program Integrity (Disclosure of Ownership/Controlling Interest)

Medicaid Managed Care health plans are required to collect specific information from network Providers prior to contracting and during credentialing to ensure that it complies with Federal regulations that require monitoring of Federal and State sanctions and exclusions databases. This monitoring ensures that any network Providers and the following details of any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against these sources, ensuring compliance with Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b). The categorical details required and collected are as follows:

1. Molina requires a current and complete Disclosure of Ownership and Control Interest Form during the credentialing process. Molina screens all individual names and entities listed on the form against the OIG, SAM, Medicare Opt-Out and each State's specific Program Integrity Unit databases at the time of initial credentialing and recredentialing. These individual names and entities are also

screened monthly for any currently sanctioned/excluded/terminated individuals or entities. Molina will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity This monitoring ensures that any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against Federal and State agency sources, ensuring compliance with 42 CFR §455. The following categorical details are collected and required on the Disclosure of Ownership and Control Interest during the credentialing and recredentialing process:

a. Detailed identifying information for any individual who has ownership or controlling interest in the individual/entity being contracted if that individual has a history of criminal activity related to Medicaid, Medicare, or Title XX services (see 42 CFR §455.106).

b. Detailed identifying information for all individuals who exercise operational or managerial control either directly or indirectly over daily operations and activities (see 42 CFR §455.101).

c. Detailed identifying information for all individuals or entities that have a five percent (5%) or more ownership or controlling interest in the individual/entity being contracted (see 42 CFR §455.104).

2. Molina requires the Disclosure of Ownership and Control Interest Form be reviewed and re-attested to every thirty-six (36) months to ensure the information is correct and current.

3. Molina screens the entire contracted Provider network against the OIG, SAM, Medicare Opt-Out, each State's specific Program Integrity Unit and Social Security Death Master File databases at initial credentialing and recredentialing, as well as, monthly for any currently sanctioned/excluded/terminated individuals or entities. Molina will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity.

4. Molina will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers. Molina will immediately terminate any employment, contractual and control relationships with an excluded individual and entity that it discovers.

5. If a State specific Program Integrity Unit notifies Molina an individual or entity is excluded from participation in Medicaid, Molina will terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately.

Office Site and Medical Record Keeping Practices Review

A review of office sites where you see Molina Members may be required. This review may be scheduled as soon as the Credentialing Department receives your application. This may also include a review of your medical record keeping practices. A passing score is required to complete the application process. Your cooperation in working with the site review staff and implementing any corrective action plans will expedite a credentialing decision.

Office site and medical record keeping reviews may also be initiated if any Member complaints are received regarding the physical accessibility, physical appearance or adequacy of waiting room and examining room space.

Range of Actions, Notification to Authorities and Provider Appeal Rights

Molina uses established criteria in the review of Providers' 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 Providers 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 Provider 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 Providers who are contracted by Molina. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. If at any point a Provider 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 Provider 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 Provider from the Molina network include, but are not limited to, the following:

1. The Provider's professional license in any state has or 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. Provider has or 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 Provider's acts, omissions or conduct.
3. Provider 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 Provider to Molina members.
4. Provider has or 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. Provider 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 Provider has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the Provider 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 Provider's practice.
6. Provider has or 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. Provider has or has ever had any denials, limitations, suspensions or terminations of participation of privileges or surrendered privileges while under investigation by any health care institution, plan, facility or clinic.
8. Provider'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. Provider has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
10. Provider has or has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the Provider's professional conduct or the health, safety or welfare of Molina Members.
11. Provider has or has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.
12. Provider has or has ever had 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. Provider has not complied with Molina's quality assurance program.
14. Provider is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
15. Provider has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Provider makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
17. Provider has ever rendered services outside the scope of their license.
18. Provider has or has ever had 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. Provider has or has ever failed to comply with the Molina Medical Record Review Guidelines.
20. Provider has or has ever failed to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring Providers on a "Watch Status" by the Committee

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

When a Provider 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 recommendation.

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 Provider 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 (6) months

Within ten (10) calendar days of the Credentialing Committee's decision to place Provider on a corrective action plan, the Provider will be notified 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 Provider'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 Provider continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate Provider response to corrective action will be brought to the Credentialing Committee for review and decision.

Summary Suspension

In cases where the Credentialing Committee or the Medical Director becomes aware of circumstances that pose an immediate risk to patients, the Provider 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 Provider of the suspension by written notification sent via certified letter. Notification will include the following:

- A description of 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 Provider.
- The length of the suspension.
- The estimated timeline for determining whether or not to reinstate or terminate the Provider.
- Details regarding the Providers right to request a fair hearing within thirty (30) calendar days of receipt of the notice and their right to be represented by an attorney or another person of their choice (see Fair Hearing Plan policy).
- If the Provider does not request a fair hearing within the thirty (30) calendar days, they have waived their rights to a hearing.
- The action will be reported to the NPDB if the suspension is in place longer than thirty (30) calendar days.

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 Provider's continued participation, discontinue the suspension or terminate the Provider.

Denial

After review of appropriate information, the Credentialing Committee may determine that the Provider should not be approved for participation in the Molina network. The Credentialing Committee may then vote to deny the Provider.

The Provider will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of denial via certified mail, from the Medical Director, which includes the reason for the denial.

Termination

After review of appropriate information, the Credentialing Committee may determine that the Provider does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing Committee may then vote to terminate the Provider.

Terminations for reasons other than unprofessional conduct or quality of care

If the termination is based on reasons other than unprofessional conduct or quality of care, the Provider will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of termination via certified mail, from the Medical Director, which includes the following:

1. A Description of the action being taken
2. Reason for termination

Terminations based on unprofessional conduct or quality of care

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

Within ten (10) calendar days of the Committee's decision, the Provider 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 Provider's right to request a fair hearing within thirty (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 Provider does not request a fair hearing within the thirty (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.
- Provider's right to be represented by an attorney or another person of their choice.
- Obligations of the Provider regarding further care of Molina Patients/Members.
- The action will be reported to the NPDB and the State Licensing Board.

Molina will wait thirty (30) calendar days from the date the terminated Provider received the notice of termination. If the Provider requests a fair hearing within that required timeframe, Molina will follow the Fair Hearing Plan Policy. Once the hearing process is completed, the Provider 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 Provider remains in the Molina network, the action will not be reportable to the State Licensing Board or to the NPDB.

If the Provider does not request a hearing within the thirty (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 Provider 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 Molina Fair Hearing Plan Policy when the Credentialing Committee takes or recommends certain Adverse Actions for a Provider 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 fifteen (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 Provider 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 Provider's credentials file. The action is also reported to other applicable State entities as required.

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 and the National Practitioner Data Bank (NPDB).

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 and the NPDB.

B. 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.

C. 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 and the NPDB.

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 and the NPDB.

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

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. 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.

J. 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.

K. 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.

L. 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.

M. 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.

N. 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.

O. 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.

P. 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.

Q. Postponements

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

R. 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.

S. 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.

T. 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 and the NPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

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

U. 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.

V. Confidentiality and Immunity

Information regarding any 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 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 Provider's provision of patient care services.

By providing patient care services at Molina, a Provider:

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the 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;

2. Actions reducing, suspending, terminating or revoking a 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 Provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a 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 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 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.

PROVIDER DISPUTE RESOLUTION and MEMBER APPEALS

Member Grievance and Appeal Process

Molina Healthcare Members or Member's personal representatives have the right to file a grievance and/or submit an appeal through a formal process. This section addresses the identification, review and resolution of Member grievances and appeals. Below is Molina Healthcare's Member Grievance and Appeals Process.

Grievance Process: How do I report a grievance?

Grievances are complaints about:

- The way you were treated,
- The quality of care or services you received,
- Problems getting care,
- Billing issues.

If you need help filing a grievance, call (800) 869-7165. We will let you know we received your grievance within two business days. We will try to take care of your grievance right away. We will resolve your grievance within 45 days and tell you how it was resolved.

Appeal Process

An appeal is a request to review a denied service or referral. You can appeal our decision if a service was denied, reduced, or ended early. Below are the steps in the appeal process:

STEP 1: Molina Healthcare Appeal
STEP 2: State Hearing
STEP 3: Independent Review
STEP 4: Health Care Authority (HCA) Board of Appeals Review Judge

Continuation of Services During the Appeal Process

If you want to keep getting previously approved services while we review your appeal, you must tell us within 10 calendar days of the date on your denial letter. If the final decision in the appeal

process agrees with our decision, you may need to pay for services you received during the appeal process.

STEP 1 – Molina Healthcare Appeal: How do I ask for an appeal?

You have 60 calendar days after the date of Molina's denial letter to ask for an appeal. You or your representative may request an appeal or may submit information about your case over the phone, in person, or in writing. You may fax the information to (877) 814-0342. Within 5 calendar days, we will let you know in writing that we got your appeal. Molina can help you file your appeal. If you need help filing an appeal, call (800) 869-7165.

You may choose someone, including a lawyer or provider, to represent you and act on your behalf. You must sign a consent form allowing this person to represent you. Molina does not cover any fees or payments to your representatives. That is your responsibility.
Before or during the appeal, you or your representative may look at and have copies of your file, medical records, or other documents considered in the appeal. If you want copies of the guidelines we used to make our decision, we can give them to you free of charge. We will keep your appeal private. We will send you our decision in writing within 14 calendar days, unless we tell you we need more time. Our review will not take longer than 28 calendar days.

STEP 2 – State Hearing: How do I ask for a legal review?

If you disagree with Molina's appeal decision, you can ask for a State Hearing. You must complete Molina's appeal process before you can have a hearing. You must ask for a hearing within 120 calendar days of the date on the appeal decision letter. When you ask for a hearing, you need to say what service was denied, when it was denied, and the reason it was denied.

Your provider may not ask for a Hearing on your behalf. To ask for a State Hearing, contact Office of Administrative Hearings:

Phone: 1-800-583-8271 P.O. Box 42489, Olympia, WA 98504-2489

You may consult with a lawyer or have another person represent you at the Hearing. If you need help finding a lawyer, check with the nearest Legal Services Office or call the NW Justice CLEAR line at 1-888-201-1014 or visit their website at www.nwjustice.org.

STEP 3 - Independent Review: How do I ask for an Independent Review?

An Independent Review is a review by a doctor who does not work for Molina. If you do not agree with the decision from the State Hearing, you can ask for an independent review within 21 calendar days of the Hearing decision or you may go directly to Step 4. Call (800) 869-7165 for help. Any extra information you want us to look at must be given to us within five days of asking for the independent review. If you ask for this review, your case will be sent to an Independent Review Organization (IRO) within three working days. You do not have to pay for this review. Molina will let you know the decision.

STEP 4 – Health Care Authority (HCA) Board of Appeals: How do I ask for another legal review?

You can ask for a final review of your case by the HCA Board of Appeals Review Judge. You must ask for this within 21 calendar days after the IRO decision is mailed. The decision of the HCA Board of Appeals is final. To ask for this review contact:

HCA Board of Appeals Phone: (360) 725-0910 Fax: (360) 507-9018
P.O. Box 42700 Toll-free: (844) 728-5212
Olympia, WA 98504-2700

Billed for services

If you get a bill for health care services, call (800) 869-7165.

Expedited (faster) Decisions

If you or your provider think waiting for a decision would put your health at risk, you may ask for an expedited (faster) appeal, state hearing, or IRO. Information that you think we need to look at must be given to us quickly. We will review your request and make a fast decision. If we decide your health is not at risk, we will let you know and we will follow the regular timeframe to make our decision.

Second Opinion

At any time you can get a second opinion about your health care or condition. Call (800) 869-7165 to find out how to get a second opinion.

Exception to Rule

Your doctor may ask us to approve a service for you that is not covered. This is called an Exception to Rule (ETR). To be approved, your need must be different from most people and no other covered, less costly service will meet your need. If we deny you a service because it is not covered, you may ask for an appeal. This decision is final. You may ask for a hearing only to review if we correctly determined the service you are asking for is not covered.

Limited Benefit

Your doctor may ask us to approve more services for you than your benefit package allows. It may be more in scope, number, length of time, or how often a service is provided. An example is more adult physical therapy visits than the 12 visits the benefit allows. This is called a Limitation Extension (LE). To be approved, it must meet the rules in WAC 182-501-0169:

- It must be asked for before you get more of the service.
- You must have gotten better from the services so far and it must be likely that you will continue to get better with more services or be likely that you would get worse without more services.

You can ask for an appeal at the same time as your doctor asks for a LE.

State-Only Funded Services are Limited

If this applies to you, we will let you know. Services paid by State Only money are limited. If the money runs out, we cannot approve the service for you even if we agree the services are needed. If you are in the middle of an appeal or a hearing when the money runs out, we cannot continue the process.

Provider Dispute Resolution Process

The Provider Dispute Resolution process (different from Appeals on behalf of Members) offers recourse for Providers who are dissatisfied with the payment or denial of a claim from Molina or any of its delegated medical groups/IPAs. Molina follows the Best Practice Recommendation for Extenuating Circumstances.

In the event a Provider would like to dispute a claim, the Provider may make an electric request via the Molina Portal, fax or e-mail: (1) within 24 months of Molina's original remittance advice date; (2) within 30 months after final determination by the primary payer. The Provider may not request payment be made any sooner than six months after Molina's receipt of the request. Any request for review of disputed claim must be submitted to Molina in accordance with the requirements stated in this section

Molina requires submission of your dispute through one of three options:

Provider WebPortal (portal login here)

To submit a dispute you will need to be in the Claims Status Inquiry module. Once you have identified the claim you are disputing you can click on the "Appeal Claim" button located at the bottom of the page. When you are ready to submit the dispute click on the "Submit" button.

The benefits of submitting your dispute request electronically via the WebPortal include:

- The member, claim number and provider information auto populate in the form
- Electronically attach chart notes or any other documentation as part of the dispute
- Type additional information you would like included in the text box regarding your dispute request. Specify why the Provider believes the services should be compensated or adjusted. If the service was denied for no prior authorization/notification you must include the extenuating circumstances as to why the prior authorization was not obtained
- In the case of coordination of benefits, include the name and mailing address of any entity that has disclaimed responsibility for payment including the denied EOB
- Receive an electric acknowledgment letter immediately following submission
- Free of charge, no more postage

Fax & Email

The Provider Dispute Resolution Request form must be completed with your request via e-mail or fax.

- Complete all elements of the Dispute Resolution Request form located at http://www.molinahealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx. Including supporting medical records and any other required documentation for review of your request. Request forms that are incomplete or missing required information will not be reviewed and will be returned to the provider without review. Disputes submitted untimely from the original decision will be denied.
- If the dispute is regarding a claim denied for no prior authorization, you must include the extenuating circumstance as why authorization was not obtained. Extenuating Circumstances include; the inability to know member had Molina coverage, the inability

to anticipate services in advance, inherent components where a service is essential to another, received misinformation from Molina, and untimely authorization decision from Molina. In the case of coordination of benefits, include the name and mailing address of any entity that has disclaimed responsibility for payment including the denied EOB. Include proof of due diligence including dated eligibility confirmation from another payer, such as eligibility screen shot and/or primary payers EOB showing denied services or ineligibility of coverage.

Additional information regarding extenuating circumstances can be found under the Best Practice Recommendation for Extenuating Circumstances.

- **Fax:** Molina Healthcare at (877) 814-0342
- **Email:** MHWProviderServicesInternalRep@Molinahealthcare.com You must complete the Dispute Resolution Request form cover sheet located on the Provider Website under the Forms section at: http://www.molinahealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx

If your claim was denied by a delegated medical group/IPA you must make your initial review request through that group. The delegated medical group/IPA addresses for dispute submission are located below. If you have a direct contract with the delegated medical group/IPA, their decision is final. All other second level reviews for providers not directly contracted with the medical group/IPA should be sent to Molina per the process above.

Molina has two levels for the dispute process. Third level dispute requests will be denied as the dispute process has been exhausted.

Request for provider disputes for medical group/IPA should be submitted to:

- Kaiser Foundation Health Plan of the Northwest:
  Kaiser Permanente NCA NW Claims
  Waterpark 1
  2500 Havana St.
  Aurora, CO 80014
  Fax: N/A

- Confluence Health :
  Molina Managed Care
  PO Box 810
  Wenatchee, WA 98807
  Fax: (509) 665-3606

The Provider will be notified of Molina's / delegated medical group IPA decision within 60 days of receipt of the provider dispute request. Providers are reminded they can NOT bill the Member when a denial for covered services is upheld.

Code Edit Policy Reconsiderations

A provider can request a reconsideration regarding a code edit policy in situations where the provider's and Molina Healthcare's correct coding policy sources conflict or where they may have different interpretations of a common correct coding policy source. The Provider will be notified

of Molina Healthcare's decision in writing within 60 calendar days of the receipt of the Code Edit Reconsideration request, unless additional supporting documentation is required.

All requests for Code Edit Policy Reconsiderations must be submitted to Molina Healthcare in writing and should include the following:

- Explanation of why the provider does not agree with Molina Healthcare's current correct coding policy or interpretation. Include the supporting alternative policy information and the source where it can be found.
- Must clearly indicate "Code Edit Policy Reconsideration Request"
- Contact information for your organizations point person, i.e. name, contact number, e-mail address
- Relevant CPT/HCPCS codes or code combination examples
- Specific claim examples of denied services related to the code edit
- Must be addressed to the attention of Molina Healthcare's Provider Services Department

Code Edit Policy Reconsiderations do not apply to eligibility limitations, non-FDA approved services, medical policies, benefit determinations or contractual disputes. Code Edit Reconsiderations should be mailed, e-mailed or faxed to the addresses listed above under Provider dispute Process.

COMPLIANCE AND OVERSIGHT MONITORING

Fraud, Waste, and Abuse

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

Mission Statement

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

Federal False Claims Act

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

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

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

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

Deficit Reduction Act

On February 8, 2006, the Deficit Reduction Act ("DRA") was signed into Law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina Healthcare, Providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state Laws pertaining to submitting false claims;
- How Providers will detect and prevent fraud, waste, and abuse;
- Employee protection rights as a whistleblowers.

The Federal False Claims Act and the Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority;
- Two times the amount of back pay plus interest;
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the Law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare will take steps to monitor Molina Healthcare contracted Providers to ensure compliance with the Law.

Definitions

Fraud: "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other

person. It includes any act that constitutes fraud under applicable Federal or State Law. (42 CFR § 455.2)

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

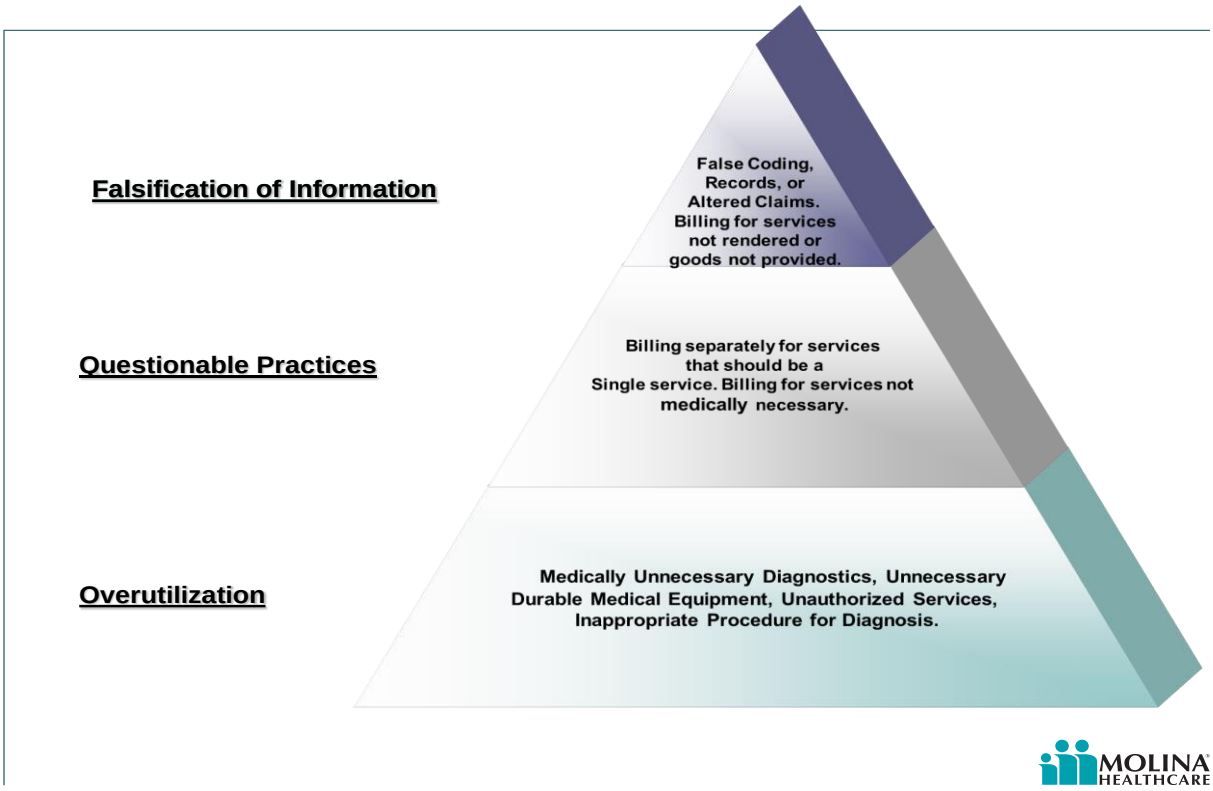
Abuse: Actions that may, directly or indirectly, result in: unnecessary costs to the Medicaid Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the Provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Examples of Fraud, Waste and Abuse by a Provider

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

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

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



Examples of Fraud, Waste, and Abuse by a Member

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

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

Review of Provider Claims and Claims System

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

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

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

Prepayment Fraud, Waste, and Abuse Detection Activities

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

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at Law or equity. In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and

records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

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

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

Review of Provider

The Credentialing Department is responsible for monitoring Providers through the various Government reports, including:

- Federal and State sanction reports.
- Federal and State lists of excluded individuals and entities
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Medicaid suspended and ineligible Provider list.
- Monthly review of State Medical Board sanctions list.
- 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 Credentialing Committee for review and potential action. The Credentialing staff will also present the list of physicians found on the sanctions report to the Compliance Committee for review and potential oversight of action.

Provider Education

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

The Molina Healthcare Provider Services Representative will inform the Provider's office that an on-site meeting is required in order to educate the Provider on certain issues identified as inappropriate or deficient.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX

Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached toll free at 1-866-606-3889 or you may use the service's website to make a report at any time at **https://molinahealthcare.alertline.com**

You may also report cases of fraud, waste or abuse using one of the below options. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Washington
Attn: Compliance
P.O. Box 4004
Bothell, Wa, 98041-4004
Fax: (800) 282-9929

Remember to include the following information when reporting:

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

Suspected fraud and abuse may also be reported directly to the State at:

Washington Healthcare Authority
Attn: Office of Program Integrity
626 8th Ave SE / P.O. Box 45503
Olympia, WA 98504-5503
Phone: (800) 562-6906
Fax: (360) 586-0212
Online: https://www.hca.wa.gov/about-hca/medicaid-fraud-prevention

Office of the Attorney General
Attn: Medicaid Fraud Control Unit
P.O. Box 40114
Olympia, WA 98504
Phone: 360-586-8888
Fax: (360) 586-8888
Online: http://www.hca.wa.gov/about-hca/program-integrity

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

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

Applicable Laws

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

1. **Federal Laws and Regulations**
    - HIPAA
    - The Health Information Technology for Economic and Clinical Health Act (HITECH)
    - Medicare and Medicaid Laws
    - The Affordable Care Act
2. **State Medical Privacy Laws and Regulations**.
    Providers should be aware that HIPAA provides a floor for patient privacy but that State Laws should be followed in certain situations, especially if the State Law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[2]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

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

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

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 to share PHI with Molina for our health care operations activities, such as HEDIS® and Quality Improvement.

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI, unless otherwise permitted by Law.

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 Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. Notice of Privacy Practices

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

2. Requests for Restrictions on Uses and Disclosures of PHI

Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. Requests for Confidential Communications

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

Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. Requests for Patient Access to PHI

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

5. Request to Amend PHI

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

6. Request Accounting of PHI Disclosures

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

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

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

HIPAA Transactions and Code Sets

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

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

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

1. Click on the area titled “I’m a Health Care Professional”
2. Click the tab titled “HIPAA”
3. And then click on the tab titled “HIPAA Transaction Readiness” or “HIPAA Code Sets”

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions. For Claims with dates of service prior to October 1, 2015, ICD-9 coding must be used. For Claims with dates of service on or after October 1, 2015, Providers must use the ICD-10 code sets.

National Provider Identifier

Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days and should also be reported to Molina within thirty (30) days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina.

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and Utilization Management activities are the “business associates” of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA’s Privacy and Security Rules.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:_____ Member ID #:_____

Member Address:_____ Date of Birth:_____

City/State/Zip:_____ Telephone #:_____

I hereby authorize the use or disclosure of my protected health information as described below.

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

_____
_____
_____

2. Name of persons/organizations authorized to receive the protected health information:

_____
_____
_____

3. Specific description of protected health information that may be used/disclosed:

_____
_____
_____

4. The protected health information will be used/disclosed for the following purpose(s):

_____
_____
_____

5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes____ No____
6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.
7. Molina may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.
8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina reserves the right to deny that health care.

9. I understand that I have a right to receive a copy of this authorization, if requested by me.
10. I understand that I may revoke this authorization at any time by notifying Molina in writing, except to the extent that:
    - action has been taken in reliance on this authorization; or
    - if this authorization is obtained as a condition of obtaining health care coverage, other Law provides the Health Plan with the right to contest a Claim under the benefits or coverage under the plan.
11. I understand that the information I authorize a person or entity to receive may be no longer protected by Federal Law and regulations.
12. This authorization expires on the following date or event*:
    _____

**If no expiration date or event is specified above, this authorization will expire 12 months from the date signed below*.

Signature of Member or Member's Personal Representative	Date
Printed Name of Member or Member's Personal Representative, if applicable	Relationship to Member or Personal Representative's Authority to act for the Member, if applicable

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) and RURAL HEALTH CLINICS (RHCs)

The Health Care Authority (HCA) pays a monthly amount, known as an enhancement rate, to clinics designated and approved as FQHCs and RHCs. There are three types of enhancement rates:

- Per Member Per Month (PMPM) premium enhancement
- Delivery Case Rate (DCR) enhancement
- BH Maternity S supplemental DCR

These enhancement rates are paid to the Managed Care Organization (MCO) by the HCA to pass along to the clinics. Each FQHC and RHC is responsible to notify Molina of any Provider enrollment changes (additions and terminations) at the clinic. Members are assigned to individual Primary Care Providers (PCP's) at the respective clinic. The monthly reporting is based on Provider information received from clinics.

PMPM Premium Enhancement

All FQHC and RHC clinics receive this premium enhancement rate established annually by HCA. Molina Healthcare submits monthly eligibility rosters to HCA, listing all Members assigned to PCPs for each of its contracted FQHCs and RHCs. HCA determines its PMPM payment based on that roster. Any payment discrepancies identified by Providers must be addressed to HCA.

DCR and BH S Rate Enhancements

Some FQHC and RHC clinics also receive a DCR or BH S rate enhancement from HCA. HCA makes a payment when a qualified FQHC or RHC provider performs a delivery for a managed care client assigned to the FQHC or RHC. These payments from HCA are triggered from the encounter data submitted by Molina to HCA. In order for this payment to be triggered, the same NPI must be:

- Used by the FQHC or RHC when billing deliveries to Molina
- Used by Molina on the monthly enhancement file sent to HCA
- Submitted in the encounter data from Molina to HCA

It is important that you notify both HCA and Molina immediately if your NPI changes to avoid any disruption to your payments.

Please note the DCR enhancement payment from HCA differs from the straight DCR claim(s) payment from Molina. Molina Healthcare does not pay claims using the encounter methodology. You may bill Molina following the HCA Medicaid Provider Guide under Physician Related Services regarding the Global (Total) Obstetrical (OB) Care or Unbundling Obstetrical guidelines.

Please contact Molina if your delivery enhancements are missing or appear to be incorrect. Molina will research all of the pertinent data elements submitted to HCA and work with HCA to resolve.

Rural Health Clinic Encounter Payment

Effective January 1, 2018 Molina will pay RHC's for encounter claims submitted directly to Molina if the RHC opted to have the MCO pay the encounter rate versus the HCA.

For RHC's that bill Molina directly for their encounter rate, they must follow the below guidelines for timely and accurate payment:

- Encounters are limited to one type of encounter per day for each client except in either one of the following circumstances:
    - It is necessary for the client to be seen by different practitioners with different specialties.
    - It is necessary for the client to be seen multiple times due to unrelated diagnoses.

- If you are billing more than one encounter per day, they must be billed on separate claims. Due to our system requirements only one encounter rate can be paid per claim. This would also include Maternity care. On each claim, indicate it is a separate encounter, enter "unrelated diagnosis" and the time of both visits in the Claim Note section of the electronic claim (modifiers 25, 59, XE, XP signify two billable visits).

- Submit professional claims with T1015 for visits that qualify as an encounter for place of service 11 or 72. **T1015 must be the last code listed on the claim** and billed as one unit in order for our system to pay your encounter claim correctly.

- Claims must be submitted using the National Provider Identifier (NPI) posted on the HCA's website as the billing NPI.

For services eligible for encounter payment, our system will automatically pay the difference between your RHC encounter rate and your Molina contracted fee for service amount paid on the T1015 line when the Molina contracted fee for service amount paid is less than the encounter rate. At this time we are not able to process claims with a negative amount on the claim line with T1015. If the Molina contracted fee for service amounts add up to more than the encounter rate, the system will cap payment at the encounter rate and there will be zero payment on the claim line with T1015.

Molina will follow the same guidelines regarding what services provided by an RHC are considered an encounter. For additional information please reference the HCA, RHC provider guide and encounter rates at https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides#r

DELEGATION - MEDICAL GROUP/IPA OPERATIONS

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

Delegation of Administrative Functions

Administrative services which may be delegated to IPAs, Medical Groups, Vendors, or other organizations include:

- Call Center
- Care Management
- Claims Administration
- Credentialing
- Non-Emergent Medical Transportation (NEMT)
- Utilization Management (UM)

Credentialing functions may be delegated to Capitated or Non-Capitated entities, which meet National Committee for Quality Assurance© (NCQA©) criteria for credentialing functions. Call Center, Claims Administration, Care Management and/or Utilization Management functions are generally only delegated to Vendors or full risk entities. Non-Emergent Medical Transportation (NEMT) may be delegated to Vendors who can meet Call Center, Claims Administration and/or NEMT requirements.

Note: The Molina Member's ID card will identify which group the Member is assigned. If Claims Administration 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.

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 for the Medicaid lines of business.

IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
Kaiser Foundation Health Plan of the Northwest	KPNW	IMC-AH (IMC Apple Health) IMC-AHA (IMC Apple Health Adult) IMC-BD (IMC Apple Health Blind Disabled) IMC-PREM (IMC Apple Health w Premium)	**Physical Health Services only**: Waterpark 1 2500 Havana St Aurora, CO 80014 **Behavioral Health Services including Mental Health and Substance use disorder**: Molina Healthcare PO Box 22612 Long Beach, Ca 90801	**For Physical Health Services KPNW**: Phone: (800) 813-2000 Fax: (877) 800-5456 **For Behavioral Health Services including Mental Health and Substance use disorder** **Molina Healthcare**: Phone: (800) 869-7185 Fax: (800) 767-7188
IPA / CAP Group Name	**ID Card Acronym**	**CAP Lines of Business**	**Claims Remit to Address**	**Referral / Authorization Information**
Kaiser Foundation Health Plan of the Northwest	KPNW	AHPREM (Apple Health with Premium) AHFAM (Apple Health Family/Pregnancy Medical) AHA (Apple Health Adult) AHBD (Apple Health Blind Disabled)	**Physical Health Services and Behavioral Health Services**: Waterpark 1 2500 Havana St Aurora, CO 80014	**Physical Health Services and Behavioral Health Services KPNW**: Phone: (800) 813-2000 Fax: (877) 800-5456

IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
Confluence Health	Confluence Health CAP	AHPREM (Apple Health with Premium) AHFAM (Apple Health Family/Pregnancy Medical) AHA (Apple Health Adult)	PO Box 810 Wenatchee, WA 98807-0810 or EDI Payor # = 91064	Confluence Health: Phone: (800) 691-1224 Fax: (509) 665-3606
IPA / CAP Group Name	**ID Card Acronym**	**CAP Lines of Business**	**Claims Remit to Address**	**Referral / Authorization Information**

Confluence Health	Confluence Health CAP	IMC-AH (IMC Apple Health) IMC-AHA (IMC Apple Health Adult) IMC-PREM (IMC Apple Health w Premium)	**Physical Health Services only**: PO Box 810 Wenatchee, WA 98807-0810 or EDI Payor # = 91064 **Behavioral Health Services including Mental Health and Substance use disorder**: Molina Healthcare PO Box 22612 Long Beach, Ca 90801 or EDI Payor # = 38336	**Physical Health Services**: Confluence Health: Phone: (800) 691-1224 Fax: (509) 665-3606 **For Behavioral Health Services including Mental Health and Substance use disorder** **Molina Healthcare**: Phone: (800) 869-7185 Fax: (800) 767-7188

AHBD or IMCAHBD - Apple Health Blind Disabled is not capitated with Confluence Health. Prior authorization request and claims should be submitted directly to Molina Healthcare*.**

NOTE: The Member's Molina Healthcare ID card will identify the group the Member is assigned to by the acronyms listed above**.** If Claims payment and/or UM has been delegated to the group, the ID card will show the delegated group's remit address and phone number for prior authorizations.

The below table shows all contracted PCP capitated groups. These groups receive a per member per month capitation payment to manage all primary care services only for their assigned membership. When seeing a new member verify if the member is assigned to a PCP capitated group by looking at their ID card or verifying eligibility on the web portal. If the member is assigned to a PCP capitated group the member must be seen by their assigned PCP or a PCP change needs to be made to the appropriate PCP prior to services being rendered.

PCP CAPITATION GROUPS	ACRONYM
Community Health Associates Spokane	CAP - CHAS
Family Care Network	CAP - FCN
Pacific Physicians	CAP – Pacific Physicians
Pierce Unicare IPA	CAP – Pierce Unicare

Delegation Criteria

Molina is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted IPAs, Medical Groups, or Vendors. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

Call Center

To be delegated for Call Center functions, Vendors must:

- Have a Vendor contract with Molina (Molina does not delegate call center functions to IPAs or Provider Groups).
- Have a Call Center delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Correct deficiencies within the timeframes identified in the correction action plan (CAP) when issues of non-compliance are identified by Molina.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste and Abuse.
- Must have an automated call system that allows the Vendor to confirm Member benefits and eligibility during the call.
- Agree to Molina's contract terms and conditions for Call Center delegates.
- Submit timely and complete Call Center delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Current call center is able to demonstrate compliance with service level performance for average speed to answer, abandonment rate, and/or percentage of calls that are complaints meet CMS and/or state requirements, depending on the line(s) of business delegated.

A Vendor may request Call Center delegation from Molina through Molina's Delegation Oversight Manager or through the Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Call Center responsibilities is based on the Vendor's ability to meet Molina, State and Federal requirements for delegation.

Care Management

To be delegated for Care Management functions, Medical Groups, IPAs and/or Vendors must:

- Be certified by the National Committee for Quality Assurance (NCQA) for complex case management and disease management programs.
- Have a current complex case management and disease management program descriptions in place. Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Pass a care management pre assessment audit, based on NCQA and State requirements, and Molina business needs.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for care management delegates.
- Submit timely and complete Care Management delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.

- Comply with all applicable federal and state Laws.

Note: Molina does not allow care management delegates to further sub-delegate care management activities.

A Medical Group, IPA, or Vendor may request Care Management from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Care Management responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Claims Administration

To be delegated for Claims Administration, Medical Groups, IPAs, and/or Vendors must do the following:

- Have a capitation contract with Molina and be in compliance with the financial reserves requirements of the contract.
- Be delegated for UM by Molina.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
- Have a Claims Administration delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements for Claims Administration.
- Correct deficiencies within timeframes identified in the correction action plan (CAP) when issues of non-compliance are identified by Molina.
- Must have an automated system capable of accepting electronic claims in an ICD 10 compliant format.
- Must have an automated system capable of providing Molina with the Encounter Data required by the state in a format readable by Molina.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Agree to Molina's contract terms and conditions for Claims Delegates.
- Submit timely and complete Claims Administration delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Within forty five (45) days of the end of the month in which care was rendered, provide Molina 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 thirty (30) days of Molina'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's contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Molina's Claims Administration policies and

guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims.

A Medical Group, IPA, or Vendor may request Claims Administration delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Claims Administration responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Credentialing

To be delegated for credentialing functions, Medical Groups, IPAs, and/or Vendors must:

- Pass Molina's credentialing pre-assessment with a score of at least 90%, which is based on NCQA credentialing standards.
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of practitioners included in delegation.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against OIG, SAM, and published state Medicaid exclusion lists a minimum of every thirty days.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina
- Agree to Molina's contract terms and conditions for credentialing delegates
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact
- Comply with all applicable federal and state Laws
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members

Note: If the Medical Group, IPA, or Vendor is an NCQA© Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modification to the audit depends on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Medical Group, IPA, or Vendor 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. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, 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, or Vendor may request Credentialing delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Credentialing responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Utilization Management (UM)

To be delegated for UM functions, Medical Groups, IPAs, and/or Vendors must:

- Have a UM program that has been operational at least one year prior to delegation, and includes an annual UM Program evaluation and annual Inter Rater Reliability audits of all levels of UM staff.
- Pass Molina's UM pre-assessment, which is based on NCQA, State and Federal UM standards, and Molina Policies and Procedures with a score of at least 90%.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Ensure that only licensed physicians/dentists medical necessity denial decisions.
- Ensure that only appropriate levels of clinical staff make medical necessity approval decisions.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Agree to Molina's contract terms and conditions for UM delegates.
- Submit timely and complete UM delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- 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: If the Medical Group, IPA, or Vendor is an NCQA© Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modifications to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable State requirements and Molina Business needs.

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

A Medical Group, IPA, or Vendor may request UM delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to

delegate UM responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Quality Improvement/Preventive Health Activities

Molina does not delegate Quality Improvement activities to Provider organizations. Molina will include all network Providers, including those in Medical Groups, IPAs, or Vendors who are delegated for other functions (Claims, Credentialing, UM, etc.) in its Quality Improvement Program activities and preventive health activities. Molina encourages all contracted Provider organizations to conduct activities to improve the quality of care and service provided by their organization. Molina would appreciate receiving copies of studies conducted or data analyzed as part of the Medical Group, IPA, or Vendor's Quality Improvement Program.

Delegation Reporting Requirements

Medical Groups, IPAs or Vendors, contracted with Molina and delegated for various administrative functions must submit monthly and quarterly reports determined by the function(s) delegated to the identified Molina Delegation Oversight Staff within the timeline indicated by the Health Plan. For a copy of Molina's current delegation reporting requirements, please contact your Molina Provider Services Contract Manager.

Capitation Models

Molina Healthcare employs a variety of Capitation reimbursement models; only organizations or individuals with a significant number of Members to spread the financial risk are approved for capitation contracts.

Primary Care Capitation: An individual PCP or a group of PCPs receive a monthly prepaid amount from Molina Healthcare as compensation for a contractually defined set of services, which are designated as capitated by Molina Healthcare.

Full Risk/Global Capitation: IPA or PHO receives a monthly prepaid amount from Molina Healthcare as compensation for a contractually defined set of services, which are designated as capitated by Molina Healthcare. These services are typically global in nature (i.e., these groups have assumed financial responsibility for all covered health care services unless specifically carved out by Molina Healthcare). Financial responsibility for all services (including carve outs) is defined in the financial responsibility matrix attached to the full risk/global Capitation agreement.

Financial Viability of Capitated Organizations

Molina Healthcare is obligated to monitor the financial status of the groups to whom it has given financial risk. This is a contractual and business responsibility. We use all reasonable methods to prevent placing an organization at risk for more than they are able to manage. We work to ensure there is little risk to any Providers who would look to the organization for payment of Claims. Prior to the initial contracting under a capitation model with an organization, Molina Healthcare assesses the organization's financial condition by reviewing the two most recent years audited financial statements and year-to-date unaudited financial statements for the current year.

Physician Incentive Plan (PIP)

Every year, Molina Healthcare is required to submit a report to HCA disclosing incentive terms for all Provider contracts. For Providers/Provider groups with substantial financial risk (any organization that could be adversely or positively affected financially by the referral volume of its Members), Molina Healthcare is required to disclose additional documentation. Organizations with substantial financial risk must provide information to Molina Healthcare including:

- Mode of payments to Providers and any payment plans considered to be PIPs
- Evidence of stop-loss protection
- Evidence of annual Member satisfaction surveys

Reporting Requirements of Organizations

Once contracted, Molina Healthcare expects all organizations, identified as bearing substantial financial risk on the PIP, to submit the following documents to Molina Healthcare:

Complete quarterly financial statements including:

- Balance Sheet
- Income Statement
- Statement of Cash Flows
- Audited annual financial statements

Organizations delegated for Claims may have additional reports required to assist Molina Healthcare in fulfilling its financial oversight responsibilities.

Capitation Operations

Joint Operations Committee Meetings: Molina Healthcare is available to meet as needed to address operational or contractual issues. On a quarterly basis, Molina Healthcare tries to meet with each of its organizations that operate under a capitation model. The purpose of the meetings is to:

- Identify any operational difficulties between the organization and Molina Healthcare and determine plans for a remedy
- Educate one another on changes to either the organization or Molina Healthcare
- Provide an opportunity for staff to meet their counterparts in order to facilitate more productive interactions

The meetings are facilitated by the Provider Services Representative, but include any other Molina Healthcare staff who may be pertinent to issues at hand.

Funds Flow Document: Because the contract is a lengthy and somewhat complicated document, Molina Healthcare works with the capitated organization to write a Funds Flow document outlining:

- Payment rates
- Mode of payment
- Division of financial responsibility
- Any special payment arrangements

The purpose of this document is to provide all involved staff at the organization and Molina Healthcare with a guide for adhering to the terms of the contract.

Encounter Reporting

Each capitated organization delegated for Claims payment is required to submit encounter data for all adjudicated Claims. The data is used for many purposes, such as reporting to the Medicaid Statistical Information System (MSIS), Apple Health rate setting and risk adjustment, HCA's hospital rate setting, the quality improvement program and HEDIS reporting.

The encounter data reporting specifications can be found at http://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/Pages/guidanceinfo.aspx.

CULTURAL COMPETENCY

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency and Members who are deaf, hard of hearing or have speech or cognitive/intellectual impairments. Policies and procedures address how 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.

Additional information on cultural competency and linguistic services is available at www.molinahealthcare.com, from your local Provider Services Representative.

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-

English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/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.

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

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

Should you or a Molina Member need more information you can refer to the Health and Human Services website for more information: https://www.federalregister.gov/d/2016-11458

Molina Institute for Cultural Competency

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

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services or online training modules.
Training modules, delivered through a variety of methods, include:

1. Written materials;
2. On-site cultural competency training delivered by Provider Services Representatives;
3. Access to enduring reference materials available through Health Plan representatives and the Molina website; and
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement – Ensuring Access

Molina ensures Member access to language services such as oral interpreting, American Sign Language (ASL), written translation and access to programs, and aids and services that are congruent with cultural norms. Molina supports Members with disabilities, and assists Members with Limited English Proficiency.
Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats, leading

to better communication, understanding and Member satisfaction. Online materials found on www.molinahealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.
Key Member information, including Appeals and Grievance forms, are also available in threshold languages on the Molina Member website.

Program and Policy Review Guidelines

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

Annual collection and analysis of race, ethnicity and language data from:

- Eligible individuals to identify significant culturally and linguistically diverse populations with plan's membership
- Revalidate data at least annually
- Contracted Providers to assess gaps in network demographics

- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
- Applicable national demographics and trends derived from publicly available sources
- Network Assessment
- Collection of data and reporting for the Diversity of Membership HEDIS measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS and CAHPS results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.
- Comparison with selected measures such as those in Healthy People 2010

Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES) Linguistic Services

Molina provides oral interpreting of written information to any plan Member who speaks any non-English language regardless of whether that language meets the threshold of a prevalent non-English language. Molina notifies plan Members of the availability of oral interpreting services upon enrollment, and informs them how to access oral interpreting services at no cost to them on all significant Member materials. Molina serves a diverse population of Members with specific cultural needs and preferences. Providers are responsible for supporting access to interpreter services at no cost for Members with sensory impairment and/or who have Limited English Proficiency.

24 Hour Access to Interpreter Services

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina

Members interpreter services if the Members do not request them on their own. It is never permissible to ask a family member, friend or minor to interpret.

Documentation

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

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic member lists that are sent to you each month by Molina.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of his or her right to have a qualified interpreter at no cost.

Members with Hearing Impairment

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center (M&PCC), Quality, Healthcare Services and all other health plan functions.
Molina strongly recommends that Provider offices make available assistive listening devices for members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the provider's voice to facilitate a better interaction with the member.
Molina will provide face-to-face service delivery for ASL to support our members with hearing impairment. Requests should be made three days in advance of an appointment to ensure availability of the service. In most cases, members will have made this request via Molina Member Services.

Nurse Advice Line

Molina provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina Healthcare's Nurse Advice Line directly (English line (888) 275-8750) or (Spanish line at (866) 648-3537) or for assistance in other languages. The Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

BENEFIT INDEX

Benefit Index Apple Health – Effective July 1, 2018

http://www.molinahealthcare.com/providers/wa/medicaid/manual/PDF/16-benefit-index-apple-health-effective-July-2018.pdf

Benefit Index Apple Health IMC and BHSO – Effective July 1, 2018

http://www.molinahealthcare.com/providers/wa/medicaid/manual/PDF/17-benefit-index-imc-effective-July-2018.pdf