MOLINA HEALTHCARE

Your Extended Family.

Florida Provider Orientation

Provider Services

Molina Healthcare of Florida

History & Organization

Molina Healthcare began 30 years ago in a small medical clinic in Long Beach, California. It was there that the Molina family children swept the floors, stocked shelves and filed medical records.

That year was 1980 and the healthcare environment was similar to that of today. Patients without a family physician would flock to emergency departments complaining of a sore throat or the flu. As an emergency room physician, Dr. C. David Molina knew that treating patients for simple everyday ailments in the emergency room cost more and caused longer waits for people with true emergencies.

As a result, Dr. Molina established a medical office to help those who were uninsured, non-English speaking or low income. This "medical home" enabled patients to access regular preventive care and a physician who was familiar with their health history who could provide the personalized care they couldn't get anywhere else.

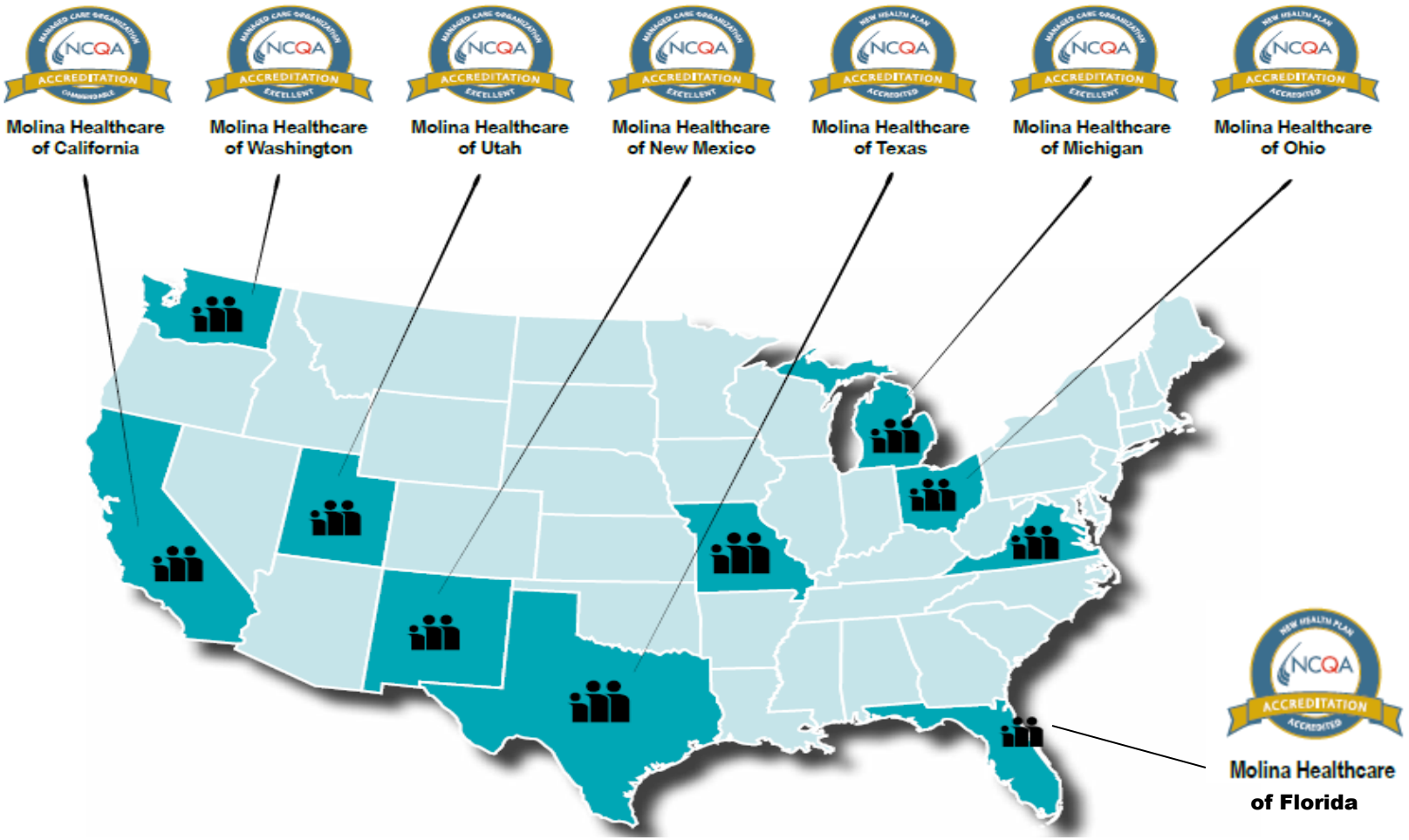
Three decades later, Molina Healthcare is still led by a physician--but not any physician, the founder's son – Dr. J. Mario Molina. He and his siblings have gone from sweeping the floors of the first clinic to running the multi-state healthcare company.

MOLINA® HEALTHCARE | Your Extended Family.

MOLINA HEALTHCARE

2005	2006	2007	2008	2009	2010
	1 million members		1.25 million members	1.45 Million Members	1.6 Million Members
Molina Healthcare of Texas begins serving communities in Harris and Bexar county areas in July 2006.	Molina begins offering services to people with **Medicare.**	**Molina Healthcare of Missouri** begins serving communities across Missouri.	**Molina Healthcare of Virginia** begins serving in Fairfax County.	Molina Healthcare of Ohio and Molina Healthcare of Texas earn NCQA accreditation.	Molina Healthcare begins offering Medicaid Management Information System (MMIS) services through Molina Medicaid Solutions.
	MOLINA MEDICARE			Molina's health plans are ranked in top 100 for 5th straight year.	MOLINA Medicaid Solutions
	Molina Healthcare of Ohio begins serving communities across Ohio.		**Molina Healthcare of Florida** begins serving select counties.		Molina Healthcare begins serving Wisconsin communities through Abri Health Plan.

NCQA Accreditation in 8 States



Molina Healthcare Among the Nation's Best

- Molina Healthcare currently has eight NCQA accredited health plans. Therefore, Molina Healthcare is placed among the national leaders in quality Medicaid accreditations.
- For six years in a row, Molina Healthcare plans have been ranked among America's top Medicaid plans by U.S. News & World Report and NCQA.
- In 2009, Molina Healthcare was listed as one of the 1,000th largest companies in the U.S. by Fortune Magazine.
- Hispanic Business magazine ranked Molina Healthcare as the nation's 2nd largest Hispanic owned company in 2009.
- Time Magazine recognized Dr. J. Mario Molina, CEO of Molina Healthcare, as one of the 25 most influential Hispanics in America.

Provider Manual

Molina Healthcare of Florida's Provider Manual is written specifically to address the requirements of delivering healthcare services to Molina Healthcare members, including your responsibilities as a participating provider. Providers may request printed copies of the Provider Manual by contacting Provider Services at (866) 472-4585, or view the manual on our website, at:

Medicaid Provider Manual - http://www.molinahealthcare.com/medicaid/providers/fl/manual/Pages/home.aspx

Medicare Provider Manual - http://www.molinamedicare.com/en-us/providers/pages/provider_splash.aspx?E=true

Provider Directory

Molina Healthcare providers may request a copy of our Provider Directory from their Provider Services Representative, or for Medicaid, providers may use the Online Directory on our website.

To find a Medicaid provider, visit us at www.molinahealthcare.com, and click Find a Provider or Find a Hospital.

To find a Medicare provider, please request a copy of our printed Provider Directory, or contact Provider Services at (866)472-4585.

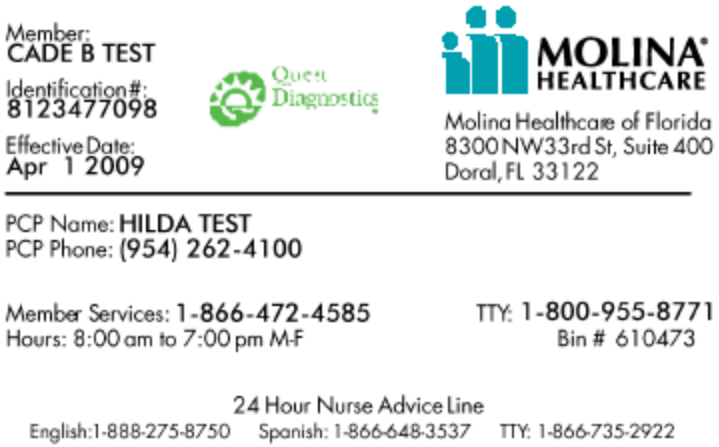
Verifying Member Eligibility

Molina Healthcare of Florida offers various tools for verifying member eligibility. Providers may use our online self-service Web Portal, integrated voice response system (IVR), or speak with a Customer Service Representative.

Web Portal :	https://eportal.molinahealthcare.com/Provider/login
Medicaid Customer Service:	(866) 472-4585
Medicaid IVR Automated System:	(866) 472-4585
Medicare Customer Service:	(866) 553-9494
Medicare IVR Automated System:	(866) 553-9494

Molina Healthcare Sample Medicaid ID Card

Molina Medicaid ID Card- Front



Molina Medicaid ID Card- Back for all non reform counties

EMERGENCY SERVICES: Call 911 if available or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go to the emergency room call your Primary Care Provider (PCP). You may also contact our 24-Hour Molina Healthcare Nurse Advisory Line at (888) 275-8750 or (866) 648-3537 (Espanol) For hearing impaired; call TTY (866) 735-2922. Follow up with your PCP after all emergency room visits.

REFERRAL SERVICES: You must have a referral from your PCP for all care or service except as noted in your Member Handbook.

PRACTITIONER/PROVIDERS/HOSPITALS: For prior authorization, post stabilization, eligibility, or benefit information call 1-866-472-4585

HOSPITAL ADMISSIONS: Authorization must be obtained by the hospital prior to all non-emergency admissions by calling Molina's Utilization Management Department 1-866-472-4585

PHARMACISTS: For RX questions, 1-800-791-6856

BEHAVIORAL/MENTAL HEALTH SERVICES Call 1-800-221-5487

LAB TESTING & SERVICES Quest Diagnostics call 1-866-MyQuest (1-866-697-8378) or go to www.QuestDiagnostic.com/patient for a center near you or appointment.

Claims Submission: PO Box 22818, Long Beach, CA 90801- EDI claims: Emdeon Payer # 51062 or Call 1-866-472-4585

www.molinahealthcare.com

Molina Healthcare Sample Medicaid ID Card – Reform Counties

Molina Medicaid ID Card- Front

Molina Medicaid ID Card- Back for reform counties

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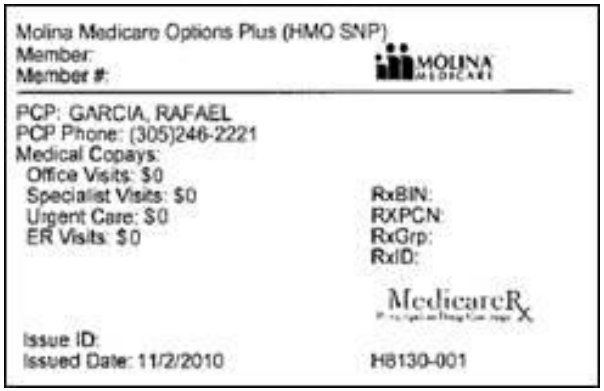
www.molinahealthcare.com

Molina Healthcare Sample Medicare ID Card

Molina Medicare ID Card- Front


Molina Medicare Options Plus (HMO SNP)
Member:
Member #:
MOLINA MEDICARE

PCP: GARCIA, RAFAEL
PCP Phone: (305)246-2221
Medical Copays:
Office Visits: $0
Specialist Visits: $0
Urgent Care: $0
ER Visits: $0

RxBIN:
RXPCN:
RxGrp:
RxID:

MedicareRx

Issue ID:
Issued Date: 11/2/2010

H8130-001

Molina Medicare ID Card- Back for all counties


Member Services: 1-866-553-9494 or TTY at 1-800-346-4128
Monday – Sunday, 8:00 AM to 8:00 PM local time
24-Hour Nurse Advice Line: 1-888-275-8750
24-Hour Nurse Advice Line TTY: 1-888-735-2929
For Spanish Please Call: 1-866-648-3537.
Providers/Hospitals: For prior authorization, eligibility and general information, please call Member Services
Submit Claims To:
Medical/Hospital:
PO BOX 22811, Long Beach, CA 90801 please call Member Services (see above)
Pharmacy:
7050 Union Park Center, Suite 200, Midvale UT 84047
please call Member Services (see above)
www.molinamedicare.com

PCP Assignment, Changes & Dismissals

PCP Assignment – Members have the right to choose their PCP. If the Member or his/her designated representative does not choose a PCP, one will be assigned using the following considerations:

- Reasonable proximity to the Member's home
- Member's last PCP, if known
- Member's covered family members, in an effort to keep family together
- Member's Age

PCP Changes – Members may change their PCP at any time with the change being effective no later than the beginning of the month following the request for the change.

PCP Dismissals – A PCP may find it necessary to dismiss a Member from his/her practice due to member non-compliance with recommended health care, or unruly and disorderly behavior. It is recommended that PCPs counsel Members prior to dismissal from the practice and allow sufficient time for the behavior to improve. If the dismissal is inevitable, PCPs must immediately notify both the Member and Molina Healthcare of Florida of the dismissal and continue treating the member for a minimum of 60 days following the notification to the Member and Molina Healthcare of Florida for non-complaint members , and 30 days (emergency care only) for unruly and disorderly Members.

Referrals &Authorizations

Referrals are made when medically necessary services are beyond the scope of the PCPs practice. Most referrals to in-network specialists do not require an authorization from Molina Healthcare of Florida. Information should be exchanged between the PCP and Specialist to coordinate care of the patient.

Prior Authorization is a request for prospective review. It is designed to:

- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for Members receiving services
- Identify Case Management and Disease Management opportunities
- Improve coordination of care

Requests for services on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and trained staff that have authority to approve services.

Molina Healthcare of Florida's Prior Authorization Guide is included in your Welcome Kit, and also on our website, at:

Medicaid - http://www.molinahealthcare.com/medicaid/providers/fl/forms/Pages/fuf.aspx

Medicare - http://www.molinamedicare.com/en-us/providers/pages/provider_splash.aspx?E=true

Requests for Authorization

Authorization for elective services should be requested with supporting clinical documentation at least 14 days prior to the date of the requested service. Authorization for emergent services should be requested within one business day. Information generally required to support decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services
- Physical examination that addresses the problem
- Lab or radiology results to support the request (Including previous MRI, CT, Lab or X-ray report/results)
- PCP or Specialist progress notes or consultations
- Any other information or data specific to the request

Molina Healthcare of Florida will process all "non-urgent" requests in no more than 14 calendar days of the initial request. "Urgent" requests will be processed within 72 hours of the initial request.

Providers who request prior authorization approval for patient services and/or procedures can request to review the criteria used to make the final decision.

Providers may request to speak to the Medical Director who made the determination to approve or deny the service request.

Service Request Form

Providers should send requests for prior authorizations to the Utilization Management Department using the Molina Healthcare of Florida Service Request Form , which is included in your Welcome Kit and available on our website, at:

Medicaid - http://www.molinahealthcare.com/medicaid/providers/fl/forms/Pages/fuf.aspx

Medicare - http://www.molinamedicare.com/en-us/providers/pages/provider_splash.aspx?E=true

Service Request Forms may be faxed to the Utilization Management Department to the numbers listed below, or submitted via our Provider Web Portal.

Web Portal : https://eportal.molinahealthcare.com/Provider/Login

Medicaid Fax: (866)-440-9791

Medicare Fax: (866) 472-9509

Drug Formulary

The Molina Drug Formulary was created to help manage the quality of our Members' pharmacy benefit. The Formulary is the cornerstone for a progressive program of managed care pharmacotherapy. Prescription drug therapy is an integral component of your patient's comprehensive treatment program. The Formulary was created to ensure that Molina Healthcare of Florida members receive high quality, cost-effective, rational drug therapy. Molina Healthcare of Florida's Drug Formularies are included in your Welcome Kit and available on our website, at:

Medicaid Formulary - http://www.molinahealthcare.com/medicaid/providers/fl/drug/Pages/formulary.aspx

Medicare Formulary http://www.molinamedicare.com/en-us/providers/pages/provider_splash.aspx?E=true

Prescriptions for medications requiring prior approval, most injectable medications or for medications not included on the Molina Drug Formulary may be approved when medically necessary and when Formulary alternatives have demonstrated ineffectiveness. When these exceptional needs arise, providers may fax a completed Prior Authorization / Medication Exception Request form to (866) 236-8531.

The Prior Authorization / Medication Exception Request is included in your Welcome Kit and available on our website, at:

Medicaid - http://www.molinahealthcare.com/medicaid/providers/fl/drug/Pages/authorization.aspx

Medicare - http://www.molinamedicare.com/en-us/providers/pages/provider_splash.aspx?E=true

Medicaid Monthly Prescription Drug Limitation

To prevent polypharmacy, Molina Healthcare of Florida limits member prescriptions to 8 prescriptions per month. This limitation does NOT apply to the agents listed on our Preferred Drug & Maintenance List.

The Preferred Drug and Maintenance List is included in your Welcome Kit and available on our website, at:

http://www.molinahealthcare.com/medicaid/providers/fl/drug/Pages/formulary.aspx

Prescribing providers may also request that members with chronic illnesses receiving more than 8 medically necessary, prescribed medications be exempted from the prescription limit. This may be done by submitting the Prescription Limit Exemption Form to (866) 236-8531.

The Prescription Limit Exemption Form is included in your Welcome Kit and available on our website at:

http://www.molinahealthcare.com/medicaid/providers/fl/pdf/exemption%20form%202.25.11.pdf?E=true

Claims Address

Medicaid Claims Submission Address

Molina Healthcare of Florida
P.O. Box 22812
Long Beach, CA 90801

Medicare Claims Submission Address

Molina Medicare
P.O. Box 22811
Long Beach, CA 90801

EDI Claims Submission – Medicaid & Medicare

Emdeon Payor ID# 51062
Emdeon Telephone (877) 469-3263

Electronic Funds Transfer & Remittance Advice (EFT & ERA)

Participating providers are encouraged to register with FIS ProviderNet for Electronic Funds Transfer and Electronic Remittance Advice. You may register after you have received your first check from Molina Healthcare. Below are the step-by-step registration instructions.

If you have never registered with FIS ProviderNet, perform the following steps:

1. Go to https://providernet.adminisource.com
2. Click Register
3. Accept the Terms
4. Verify your information

4a. Select Molina Healthcare from the Payers list
4b. Enter your primary NPI
4c. Enter your primary Tax ID
4d. Enter a recent Claim Number and/or Check Number associated with this Tax ID and Molina Healthcare

5. Enter your User Account Information

5a. Use your email address as your user name
5b. Strong passwords are enforced (at least 8 characters consisting of letters and numbers)

6. Verify your Contact Information
7. Verify your Bank Account Information
8. Verify your Payment Address

8a. Note: any changes to this address may interrupt the EFT process

9. Be sure to add any additional payment addresses, accounts, and Tax IDs once you have logged in.

If you are associated with a Clearinghouse, perform the following steps:

1. Go to Connectivity
2. Click the Clearinghouses tab
3. Select the Tax ID for which this clearinghouse applies
4. Select a Clearinghouse
5. If applicable, enter your Trading Partner ID
5. Select the File Types you would like to send to this clearinghouse
7. Click Save

If you are a registered FIS ProviderNet user:

1. Log in to ProviderNet
2. Click Provider Info
3. Click Add Payer
4. Select Molina Healthcare from the Payers list
5. Enter a recent check number paid by Molina Healthcare that is associated with your primary Tax ID (as indicated on the Provider Info form)

Web Portal

Molina Healthcare of Florida participating providers may register for access to our Web Portal for self service member eligibility, claims status, provider searches and to submit requests for authorization and professional claims.

Self Service registration instructions and a complete training guide for the Web Portal are included in your Welcome Kit.

Register online at, https://eportal.molinahealthcare.com/Provider/login.

Pregnancy Notification

Molina Healthcare of Florida must be notified by the PCP, Specialist or Hospital of a member's pregnancy for an unborn record number to be created by Department of Children and Families and AHCA.

PCP's and Specialists are required to immediately notify Molina Healthcare of Florida of the first prenatal visit and/or positive pregnancy test of any member presenting themselves for healthcare services. Molina Healthcare of Florida shall notify the appropriate Department of Children and Families Customer Support Center Economic Self-Sufficiency Services of a member's pregnancy.

To notify Molina Healthcare of Florida of a member's pregnancy, complete the Pregnancy Notification Form and forward it to us via fax or email to:

Pregnancy Notification Fax: (866) 440-9791

Pregnancy Notification Email: MFLBaby@MolinaHealthcare.com

The Pregnancy Notification Form is included in your Welcome Kit, and available on our website, at:

http://www.molinahealthcare.com/medicaid/providers/fl/forms/Pages/fuf.aspx

Transportation

Molina Healthcare of Florida provides non-emergency medical transportation for our Medicaid* members in Broward County and for our Medicare** members with the following Molina Medicare plans; Molina Medicare Options Plus (H8130-001) in Dade, Broward, Palm Beach, Hillsborough and Pinellas County and Molina Medicare Options (H8130-002) in Dade and Broward Counties.

If one of your patients is in need of this service, please have them contact our exclusive transportation provider listed below:

LogistiCare

Tel. (866) 528-0454

Tel. (866) 288-3133 TTY/TDD

*Transportation services in non-reform counties are not covered by Molina Healthcare of Florida, but may be covered by the State. For more information, please contact the Agency for Healthcare Administration's local Medicaid office.

**Molina Medicare Options (H8130-004) in Palm Beach, Hillsborough and Pinellas Counties does not offer non-emergent transportation as a benefit.

Laboratory Services

Quest Laboratories is the exclusive provider of laboratory services for all Molina Healthcare of Florida members.

Your patients will benefit from Quest Diagnostics comprehensive access, convenience, and choice with a broad array of services available at >200 patient locations throughout Florida.

Quest Laboratories offers:

- An extensive testing menu with access to more than 3,400 diagnostic tests so you have the right tool for even your most complicated clinical cases.
- Approximately 900 PhDs and MDs are available for consultation at any time.
- Results within 24 hours for more than 97% of the most commonly ordered tests.
- 24/7 access to electronic lab orders, results, ePrescribing and Electronic Health Records (EHR).
- Trained IT Specialists provide 24/7/365 support for all Quest Diagnostics IT solutions in your office, minimizing downtime and providing the answers you need quickly.
- Less wait time at Patient Service Center locations with Appointment Scheduling by phone or online.
- Email reminders either in English or Spanish about upcoming tests or exams.

If you do not currently use Quest Diagnostics for outpatient laboratory services or have questions about Quest Diagnostics services, test menus, and patient locations, please call 866-MY-QUEST to request a consultation with a Quest Diagnostics Sales Representative.

Medicaid Quality Improvement

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

Program Goals:

- Design and implement programs that improve care and service outcomes
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, member safety and service
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to members
- Systematic monitoring, intervention and evaluation to improve outcomes
- Improve reporting methods
- Multidisciplinary committees to facilitate quality improvement goals.
- Maintain regulatory compliance
- Evaluation of clinical and service outcomes

Medicaid Quality Improvement

The QAP assists in achieving these goals through an evaluation process of both clinical and service outcomes measuring the effectiveness of internal processes and active improvement interventions. The QAP outlines several functional aspects of the QAP that contributes to a high level of clinical and service quality.

- Health Management Programs; breathe with ease for Asthma, Healthy Living with Diabetes, Motherhood Matters high risk pregnancy program
- Preventive Care and Clinical Practice Guidelines
- Measurement of Clinical and Service Quality; HEDIS, CAHPS® (Consumer Assessment of Health plan Survey), Provider Satisfaction Survey, and Key Quality Metrics

For additional information about Molina Healthcare of Florida's Quality Improvement initiatives, visit our website at www.molinahealthcare.com.

Immunizations

Medicaid eligible recipients from birth through (18) years of age are eligible to receive free vaccines through the federal Vaccines for Children (VFC) Program. Providers are reimbursed only for the administration of the vaccines. The vaccines are free to the provider through the Vaccines for Children (VFC) program, and Department of Health.

Medicaid eligible recipients (19) through (20) years of age may receive vaccines through their health care provider. These vaccines are not free to the provider and are reimbursed by Medicaid. Reimbursement includes the administration fee and the cost of the vaccine.

For more information about vaccines, vaccine supply and contraindications for immunization, please visit the National Immunization Program Website at www.cdc.gov/nip, or call the National Immunization Hotline at (800) 232-2522.

Current immunization schedules are available on our website, at www.molinahealthcare.com.

PCP Access Standards

Type of Care	Appointment Wait Time
Preventive Care Appointment	Within 30 days of request
Routine Sick Visit	Within 7 days of request
Urgent Care	Within 24 hours
Emergency Care	Triage and treat immediately Available by phone 24 hours/7 days
After-Hours Care	Available by phone 24 hours/7 days
Office Waiting Time	Should not exceed 30 minutes

Specialist Access Standards

Type of Care	Appointment Wait Time
Routine Consultation Appointment	Within 8 weeks of request
Urgent Appointment	Within 24 hours (same day)
Pregnancy (for initial visit)	Within 2-6 weeks of request

Medicare Special Needs Model of Care (SNP)

Medicare Advantage Special Needs Plans (SNPs) are designed for specific groups of members with special health care needs. Molina Healthcare of Florida is contracted with CMS as a D-SNP for dual eligibles, or members who are eligible for both Medicare and Medicaid. Visit our website, www.molinamedicare.com for more information about Molina Healthcare of Florida's SNP Model of Care.

What is the SNP Model of Care?

The SNP Model of Care is the CMS plan for delivering case management and services for Medicare Advantage members with special needs. It sets guidelines for:

- Assessment and case management of members
- Communication among members, caregivers, and providers
- Use of an Interdisciplinary Team (ICT) of health professionals
- Integration of the primary care physician (PCP) as a key member of the ICT
- Measurement of individual and program outcomes

Molina Medicare SNP Model of Care

- Every SNP member is evaluated annually with a comprehensive Health Risk Assessment
- Members are then triaged to the appropriate Molina Medicare case management program
- An Interdisciplinary Team develops an Individualized Care Plan (ICP) with input from providers, members and their caregivers/families as appropriate
- Members receive monitoring, service referrals, and condition specific education
- Case managers and PCPs work closely together to implement and evaluate the member's Individualized Care Plan (ICP)
- Molina Medicare will disseminate evidence-based clinical guidelines and will conduct studies:
  - to measure benefits to member and Molina Medicare
  - to monitor quality of care
  - to evaluate the effectiveness of the Model of Care

Medicare Comprehensive Health Annual Assessment

All Molina Medicare members should receive a Comprehensive Annual Assessment from their PCP, at least once every year. As part of our Initial Health Risk Summary Program, Molina collects specific information about our members' health conditions from these assessments in order to improve coordination of care.

PCPs should ensure that all Molina Medicare members are assessed at least annually, and submit a completed Comprehensive Health Assessment and Evaluation Form to Molina Healthcare of Florida. We recognize that documenting this assessment creates additional work for PCPs and their staff, so we have developed a method of reimbursement to compensate providers for this service.

For additional information about our Comprehensive Health Assessment and Evaluation, contact Molina Healthcare of Florida's Provider Services Department at (866) 472-4585.

Balance Billing

Participating providers shall accept Molina Healthcare of Florida's payments as payment in full for covered services. Providers may not balance bill the Member for any covered benefit, except for applicable copayments and deductibles, if any.

As a Molina Healthcare of Florida participating provider, your office is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. In the event of a denial of payment, providers shall look solely to Molina Healthcare of Florida for compensation for services rendered.

Your Provider Agreement states the following:

Attachment E - Required Provisions (Health Care Service Plans): Provider agrees that the Member is not liable to the Provider for any services for which the Health Plan is liable as specified in F.S. 641.3154. (F.S. 641.315(1).)

Attachment F – Required Provisions (Medicaid/AHCA): Provider shall not seek payment from Members for any Covered Services provided to the Member within the terms of the Model Contract. (X C.2.a.). Providers shall look solely to Molina Healthcare of Florida for compensation for services rendered, with the exception of nominal cost sharing, pursuant to the Florida State Medicaid Plan and the Florida Coverages and Limitations Handbooks. (X C.2.b.)

Attachment H – Medicare Program Requirements – Health Care Services: Provider agrees that under no circumstance shall a Member be liable to the Provider for any sums owed by Health Plan to the Provider. Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate responsible party, for any Medicare Part A and B cost sharing that is covered by Medicaid. (42 CFR 422.504(g)(1)(i).)

Fraud, Waste & Abuse

Molina Healthcare of Florida seeks to uphold the highest ethical standards for the provision of health care services to its members, and supports the efforts of federal and state authorities in their enforcement of prohibitions of fraudulent practices by providers or other entities dealing with the provision of health care services.

“Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicare and Medicaid programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicare and Medicaid programs. (42 CFR § 455.2)

“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)

False Claims Act, 31 USC Section 3279

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. 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, President Bush signed into law the Deficit Reduction Act ("DRA"). The law, which became effective on January 1, 2007 aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare of Florida Community Plus who receive or pay out at least $5 million in Medicare and Medicaid funds per year must comply with DRA. Providers doing business with Molina Healthcare of Florida Community Plus, and their staff, have the same obligation to report any actual or suspected violation of Medicare and 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 protected rights as 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 Act(s). The whistleblower may also file a lawsuit on their own. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

The Federal False Claims Act and the Medicaid False Claims Act contain some overlapping language related to personal liability. For instance, the Medicaid False Claims Act has the following triggers:

Deficit Reduction Act

The Federal False Claims Act and the Medicaid False Claims Act contain some overlapping language related to personal liability. For instance, the Medicaid False Claims Act has the following triggers:

- Presents or causes to be presented to the state a Medicaid claim for payment where the person receiving the benefit or payment is not authorized or eligible to receive it
- Knowingly applies for and receives a Medicaid benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, and converts that benefit or payment to their own personal use
- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in furthering 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 of Washington will take steps to monitor Molina contracted providers to ensure compliance with the law.

Examples of Fraud & Abuse

Health care fraud includes but is not limited to the making of intentional false statements, misrepresentations or deliberate omissions of material facts from, any record, bill, claim or any other form for the purpose of obtaining payment, compensation or reimbursement for health care services.

By a Member	By a Provider
Lending an ID card to someone who is not entitled to it.	Billing for services, procedures and/or supplies that have not been actually been rendered
Altering the quantity or number of refills on a prescription	Providing services to patients that are not medically necessary
Making false statements to receive medical or pharmacy services	Balancing Billing a Medicaid member for Medicaid covered services
Using someone else's insurance card	Double billing or improper coding of medical claims
Including misleading information on or omitting information from an application for health care coverage or intentionally giving incorrect information to receive benefits	Intentional misrepresentation of manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of Provider/Practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "upcoding", and billing for services not provided
Pretending to be someone else to receive services	Concealing patients misuse of Molina Health card
Falsifying claims	Failure to report a patient's forgery/alteration of a prescription

Questions