2019 PROVIDER MANUAL

Molina Healthcare of Idaho, Inc.

Medicare Medicaid Coordinated Plan

Medicare Options HMO

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Dear Provider:

Welcome to Molina Healthcare of Idaho, Inc. Enclosed is your Medicare Provider Manual, written specifically to address the requirements of delivering health care services to Molina Healthcare Members.

This Provider Manual is designed to provide you with assistance in all areas of your practice, from making referrals to receiving payment for your services. In some cases, you may have developed internal procedures that meet the standards set out in this Provider Manual. In these instances, you do not need to change your procedures as long as they adhere to the standards outlined in this Provider Manual.

From time to time, this Provider Manual will be revised as policies or regulatory requirements change. All changes and updates will be updated and posted to the Molina Healthcare website as they occur. All contracted Providers will receive an updated Provider Manual annually, which will be made available at www.MolinaHealthcare.com.

Thank you for your active participation in the delivery of quality health care services to Molina Healthcare Members.

Sincerely,

Brandon Hendrickson
President
Molina Healthcare of Idaho, Inc.

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1. Introduction

Molina offers two (2) different products in Idaho for Molina's Medicare line of business:
- Molina Medicare Advantage Plan
- Molina Medicare Medicaid Coordinated Plan

Molina is licensed and approved by the Centers for Medicare & Medicaid Services (CMS) to operate in the following states: California, Florida, Idaho, Michigan, New Mexico, Ohio, Texas, Utah, Washington and Wisconsin.

Molina Medicare Options Plan (HMO) is the name of the Molina Healthcare of Idaho, Inc.'s Medicare Advantage Plan that offers all services covered by Original Medicare Parts A, B, and D. This plan is intended to give all eligible seniors exceptional coverage and access to in eligible counties. Plan benefits include an optional supplemental vision and dental benefit for an additional out-of-pocket cost. This plan is available in the following counties: Ada, Canyon, and Twin Falls.

Please contact the Member & Provider Services Contact Center Monday through Sunday from 8:00 a.m. to 8:00 p.m., local time, toll free at (844) 560-9811 with questions regarding this program. TTY/TDD users, please call 711.

Medicare Medicaid Coordinated Plan (MMCP) is the name of the Molina Healthcare of Idaho, Inc.'s Special Needs Plan (FIDE- SNP).

The Medicare Medicaid Coordinated Plan (MMCP) is a type of Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) that enrolls individuals over the age of twenty (21) that are eligible for both Medicare and Medicaid. The MMCP was created as a route to better integration between Medicare and Medicaid, in turn leading to better quality, higher value healthcare for enrollees. This plan is available in the following counties: Ada, Canyon, Banner, Bingham, Bonner, Bonneville, Nez Perce, Kootenai, and Twin Falls.

The MMCP covers all medically necessary and preventive services covered under Medicare Part A, Part B and Prescription Drug coverage under Part D, as well as most services covered by Medicaid. The MMCP also offers additional services over and above original Medicare/Medicaid, including:
- Care Coordination
- Vision
- A 24-hour Nurse Line
- A Fitness Benefit

MMCP (FIDE- SNP) embraces Molina's long-standing mission to serve those who are the most in need and traditionally have faced barriers to quality health care.

Please contact the Member & Provider Services Contact Center Monday through Sunday from 8:00 a.m. to 8:00 p.m., local time, toll free at (844) 560-9811 with questions regarding this program. TTY/TDD users, please call 711.

Use of this Provider Manual

From time to time, this Provider Manual will be revised as policies or regulatory requirements change. All changes and updates will be updated and posted to the Molina website as they occur. All contracted Providers will receive an updated Provider Manual annually, which will be made available at www.MolinaHealthcare.com.

This Provider Manual contains samples of the forms needed to fulfill your obligations under your Molina contract. If you are already using forms that accomplish the same goals, you may not need to modify them.

2. Background and Overview of Molina

Molina Healthcare, headquartered in Long Beach, California, is a national managed care company focused on providing health care services to people who receive benefits through government-sponsored programs. Molina is a health plan driven by the belief that each person deserves access to affordable, quality health care.

The company in 1980 as a provider organization with a network of primary care clinics in California. As the need to more effectively manage and deliver health care services to low-income populations grew, Molina has grown to be a health plan serving millions of Members across the country.

The Benefit of Experience

By focusing exclusively on serving low-income families and individuals who receive health care benefits through government-sponsored programs, Molina has developed strong relationships with Members, Providers and government agencies within each regional market that it serves. Molina's ability to deliver quality care, establish and maintain provider networks, and administer services efficiently has enabled it to compete successfully for government contracts.

Quality

Molina is committed to quality and has made accreditation a strategic goal for each health plan. Year after year, Molina health plans have received accreditation from the National Committee for Quality Assurance (NCQA). The NCQA accreditation process sets the industry standard for quality in health plan operations.

Flexible Care Delivery Systems

Molina has constructed its systems for health care delivery to be readily adaptable to different markets and changing conditions. Health care services are arranged through contracts with Providers that include independent Providers, medical groups, hospitals and ancillary Providers. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates and diagnostic-related groups (DRG).

Cultural and Linguistic Expertise

National census data shows that the United States' population is becoming increasingly diverse. Molina has over thirty-five (35) years of history developing targeted health care programs for a culturally diverse membership, and is well-positioned to successfully serve these growing populations by:

- Contracting with a diverse network of community-oriented Providers who have the capabilities to address the linguistic and cultural needs of Members;

- Educating employees about the differing needs among Members; and,
- Developing Member education material in a variety of media and languages and ensure the literacy level is appropriate for our target audience.

3. Contact Information for Providers

Molina Healthcare of Idaho, Inc.
7050 Union Park Center, Suite 200
Midvale, UT 84047

Provider Services Department

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

Web Portal	https://provider.MolinaHealthcare.com
Telephone	(844) 239-4914

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCP), and Member complaints. Member Services Representatives are available seven (7) days a week, from 8:00 a.m. to 8:00 p.m., local time. Eligibility verifications can be conducted at your convenience via Molina's web portal.

Telephone	(844) 239-4913
Hearing Impaired (TTY/TDD)	711

Claims Department

Although Molina requires Participating Providers to submit Claims electronically (via a clearinghouse or Molina's Provider Portal), Idaho Providers are allowed to submit paper claims.

- Access the Provider Portal
- EDI Payer ID number 61799
  - For Paper claims submittal for Idaho:
    Molina Healthcare of Idaho, Inc.
    PO Box 22617
    Long Beach, CA 90801

To verify the status of your claims, please use Molina's Provider Portal. For other claims questions contact Member Services.

Web Portal	https://provider.MolinaHealthcare.com
Telephone	(844) 239-4914

Claims Recovery Department

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

Address	Molina Options Plus Claims Recovery Department PO Box 22811 Long Beach, CA 90801
Telephone	(888) 562-5442

Compliance/Anti-Fraud Hotline

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina AlertLine or submit an electronic complaint using the website listed below. For more information about fraud, waste and abuse, please see the Compliance section of this Provider Manual.

Address	Confidential Compliance Official Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802
Telephone	(866) 606-3889
Email	https://MolinaHealthcare.AlertLine.com

Credentialing Department

The Credentialing Department verifies all information on the Provider Application prior to contracting and re-verifies this information every three (3) years. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network.

Telephone	(844) 239-4914
Fax	(801) 316-9554

24-Hour Nurse Advice Line

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

English Telephone	(844) 526-3188

Spanish Telephone	(866) 648-3537
Hearing Impaired (TTY/TDD)	711

Healthcare Services Department

The Healthcare Services (formerly UM) Department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The Healthcare Services (HCS) Department also performs Care Management for Members who will benefit from Care Management services. Participating Providers are required to interact with Molina's HCS department electronically whenever possible. Prior Authorization/Service Requests and status checks can be easily managed electronically.

Managing Prior Authorizations/Service Requests electronically provides many benefits to providers, such as:

- Easy to access to twenty-four/seven (24/7) online submission and status checks.
- Ensures HIPAA compliance.
- Ability to receive real-time authorization status.
- Ability to upload medical records.
- Increased efficiencies through reduced telephonic interactions.
- Reduces cost associated with fax and telephonic interactions.

Molina offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Molina via the Provider Portal. See Molina's Provider Web Portal Quick Reference Guide or contact your Provider Services Representative for registration and submission guidance.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Web Portal	https://provider.MolinaHealthcare.com
Fax	(866) 504-7262
Telephone	Idaho MMCP (844) 239-4913
Telephone	Idaho Molina Options (844) 560-9811

Health Management Level 1 and Health Management Department

Molina's Health Management Level 1 (previously Health Education) and Health Management (previously Disease Management) programs will be incorporated into the Member's treatment plan to address the Member's health care needs.

Telephone	(866) 472-9483, Ext. 751136 – Health Management Level 1
Telephone	(866) 472-9483, Ext. 751135 – Health Education

Fax	(800) 642-3691

Behavioral Health

Molina manages all components of covered services for Behavioral Health. For Member Behavioral Health needs, please contact Molina directly.

Telephone	(844) 526-3188 24 Hours per day, 365 day per year

Pharmacy Department

Pharmacy services are covered through CVS Caremark.

Telephone	(844) 239-4914 8:00 a.m. - 8:00 p.m. local time, 7 days a week.
Address	CVS Caremark 2211 Sanders Road, 10th Floor Northbrook, Illinois 60062 Attn: Vice President and Senior Counsel, Healthcare Services
Hearing Impaired (TTY/TDD)	711

Quality Improvement

Molina maintains a Quality Improvement (QI) Department to work with Members and Providers in administering the Molina Quality Improvement Program.

Telephone	(844) 239-4913
Fax	(855) 260-8743

Supplemental Services

Molina offers the following supplemental services benefits.

Service	Vendor Name & Address	Telephone
Dental	Avēsis Third Party Administrators, Inc. Attention: President 10324 S. Dolfield Road Owings Mills, MD 21117	(855) 214-6779
Hearing	Avēsis Third Party Administrators, Inc. Attention: President	(855) 214-6779

Service	Vendor Name & Address	Telephone
	10324 S. Dolfield Road Owings Mills, MD 21117	
Vision	March Vision Care Inc. Attn: Glenn March, MD CEO 6701 Center Drive West, Suite 790 Los Angeles, CA 90045	(844) 986-2724
Meal Services	Homestyle Direct 2032 Highland Ave Twin Falls, ID 83301	(866) 735-0921
Meal Services	Mom's Meals Nourish Care 3120 SE Corporate Woods Dr. Ankeny, IA 50021	(515) 963-7403
OTC Medications	Convey Health Solution Attention: OTC client Management 4180 Okeechobee Road Fort Pierce, FL 34947	(800) 817-5526 or www.ConveyHealthSolutions.com
Gym	Silver and Fit American Specialty Health Fitness, Inc. Attn: Chairman & CEO 10221 Wateridge Circle San Diego, CA 92150-9117	(877) 427-4788
Personal Emergency Response System (PERS)	Critical Signal Technologies Attn: Heather Sellar, CSA Vice President of Business Development-West 27475 Meadowbrook Rd Novi, MI 48377	(888) 557-4462
Transplant Services	Interlink 4660 NE Belknap Court, Suite 209 Hillsboro, OR 97124	(800) 599-9119
Transportation	Secure Transportation Company, Inc. Attn: Pilar V. Dobbs 434 E. Broadway Long Beach, CA 90802	(888) 593-2052

4. Provider Responsibilities

Nondiscrimination of Health Care 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

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 (some changes can be made online) 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 National Provider Identifier (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 and correct most of your information. A convenient Provider web form can be found on the POD and additionally on the Provider Portal at https://provider.MolinaHealthcare.com, or notify your Provider Services Representative 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 and Recredentialing 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 Network of 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.

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools, except in the state of Idaho.

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, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic claims appeal, and registration for and use of Molina's Provider Web Portal (Provider Portal).

Although Molina requires Participating Providers to submit Claims electronically (via a clearinghouse or Molina's Provider Portal), Idaho Providers are allowed to submit paper claims.
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.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers) (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at www.MolinaHealthcare.com.

If a Provider does not comply with Molina's Electronic Solution Requirements, the Provider's claim will be denied, except in the state of Idaho.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:
- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- Provider Web Portal

Electronic Claims Submission Requirement

Molina prefers Participating Providers to submit Claims electronically. Electronic claims submission provides significant benefits to the provider including:
- Promotes 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 Portal Quick Reference Guide at 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 61799, 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) offer a number of Claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper claims.

Electronic Claims submitting benefits include:
- Ability to add attachments to previously-submitted claims
- Easily and quickly void claims
- Routinely check claims status
- Receive timely notification of a change in status for a particular claim
- Ability to Save incomplete/un-submitted Claims

Create/Manage Claim Templates

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 remittance advice (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 EFTs/ERAs. 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 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 – As well as view benefits, covered services and Member Health record
- Member Roster – View a list of assigned membership for PCP(s)
- 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
  - Create and Manage Claim Templates
  - Open Saved Claims
- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization/Service Requests
  - Check status of Authorization/Service Requests
  - Receive notification of change in status of Authorization/Service Requests
  - Create Service Request/Authorization Templates
- View HEDIS® Scores and compare to national benchmarks
- Appeals
  - Create and submit a Claim Appeal
  - Add Appeal attachments to Appeal
  - Receive Email Confirmation

Third Party Billers can access and utilize all Claim Functions. Third Party Billers no longer have to phone in to get claim updates and to make changes. All Claim functionalities are now available for Third Party Billers online at Molina's Provider Portal.

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 those services that require prior authorization.

Providers may not charge Members fees for covered services beyond copayments or coinsurance.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina 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 payer such as a Medicaid Managed Care Plan is responsible for paying such amounts. Balance billing a Medicare and/or Medicaid Member for Medicare and/or Medicaid covered services is prohibited by Law. 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 and the Compliance sections of 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 Rights and Responsibilities

Providers are required to 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 of this Provider Manual.

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 Medicare 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 is available in the Eligibility and Enrollment section of this Provider Manual.

Member Cost Share

Providers should verify the Molina Member's Cost Share status prior to requiring the Molina Member to pay co-pay, co-insurance, deductible or other Cost Share that may be applicable to the Member's specific Benefit Plan. Some plans have a total maximum Cost Share that frees the Member from any further out of pocket charges once reached (during that calendar year).

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 Web Portal. Clinical documentation can be attached as a file and submitted securely through the Provider Web Portal. Please see the Healthcare Services section of this Provider Manual for additional details about these and other Healthcare Services programs.

In Office Laboratory Tests

Molina's policies allow only certain lab tests to be performed in a Provider's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found on the Molina website at www.MolinaHealthcare.com.

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory (https://providersearch.MolinaHealthcare.com). For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient service centers, please reach out to the In-Network Laboratory Provider.

Specimen collection is allowed in a Provider's office and shall be compensated in accordance with your agreement with Molina and applicable State and Federal billing and payment rules and regulations.

Claims for tests performed in the Provider's office, but not on Molina's list of allowed in-office laboratory tests will be denied.

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 Healthcare Services 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. In the case of Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care 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.

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. Each year, we review feedback received from PCPs and specialists and facilities to determine if the level of satisfaction with the information provided across settings or between Providers is sufficient.

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 section of this Provider 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. The PCP or designee must be available twenty-four (24) hours a day, seven (7) days a week to Members for Emergency Services. This access may be by telephone. For additional information about appointment access standards please refer to the Quality section of this Provider Manual.

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 for guidance.

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 Health Information (PHI) and HIPAA Transactions

Molina requires that 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. Please refer to the Compliance section of this Provider Manual for additional information.

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 and/or statement as 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 the Member Grievances and Appeals section of this Provider Manual for additional 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 and applicable accreditation, State and Federal requirements. 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. When this notification is received, a site review of the new office may be conducted before the Provider's recredentialing date.

More information about Molina's Credentialing program, including Policies and Procedures is available in the Credentialing and Recredentialing 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 the Delegation section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

5. Cultural Competency and Linguistic Services

Background

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, non-verbal, have a speech impairment, or have an intellectual disability. 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 and by calling Molina Provider Services at (844)239-4914.

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 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.

Providers can refer Molina Members who are complaining of discrimination to the Molina Civil Rights Coordinator at: (866) 606-3889, or TTY/TDD, 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.

Cultural Competency

Molina is committed to reducing health care disparities. Training employees, Providers and their staffs, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina 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/webinar training modules.

Training modules, delivered through a variety of methods, include:
1. Written materials;
2. On-site cultural competency training;
3. Online cultural competency provider training; 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, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities, and assist 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 within plan's membership.
  - Revalidate data at least annually.
  - Contracted practitioners to assess gaps in network demographics.
- Local geographic population demographics and trends derived from publicly available sources (Community Health 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.
- Determination of threshold languages annually 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 2020.

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

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Member & Provider Contact Center toll free at (888) 665-1328. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service provider.

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. Please remember 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 being notified of his or her right to have a qualified interpreter at no cost.

Members who are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection accessible by dialing **711**. This connection provides access to Member & Provider Contact Center, 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 who are deaf or hard of hearing. Requests should be made three (3) 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's Nurse Advice Line directly (English line [844] 526-3188) or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

6. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Evidence of Coverage (EOC). The EOC that is provided to Members annually is hereby incorporated into this Provider Manual. The most current EOC can be accessed via the following links:

- Medicare Medicaid Coordinated Plan
  www.MolinaHealthcare.com/ID/MMCP/EOC
  - Refer to Chapter 8 which is titled "Your Rights and Responsibilities."
  - For additional information, please contact Molina at (844) 239-4913, seven (7) days a week, 8:00 a.m. to 8:00 p.m., local time. TTY/TDD users, please call 711.

- Medicare Options HMO
  www.MolinaHealthcare.com/ID/MMO/EOC
  - Refer to Chapter 8 which is titled "Your Rights and Responsibilities."
  - For additional information, please contact Molina at (844) 239-4913, seven (7) days a week, 8:00 a.m. to 8:00 p.m., local time. TTY/TDD users, please call 711.

State and Federal Law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

Second Opinions

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

7. Eligibility and Enrollment in Molina Medicare Plans

Members who wish to enroll in Molina Medicare Options (HMO) or Molina Medicare Medicaid Coordinated Plan (HMO FIDE), must meet the following eligibility criteria:

- Be entitled to Medicare Part A and enrolled in Medicare Part B;
- Not be medically determined to have ESRD prior to completing the enrollment form (unless individual is an existing Molina Medicaid Member);
- Permanently reside in the Molina Medicare service area, which includes the following counties:
  - Medicare Options: Ada, Canyon, Twin Falls
  - MMCP: Ada, Bannock, Bingham, Bonner, Bonneville, Canyon, Kootenai, Nez Perce, and Twin Falls
- Member or Member's legal representative completes an enrollment election form completely and accurately;
- Is fully informed and agrees to abide by the rules of Molina Medicare;
- The Member makes a valid enrollment request that is received by the plan during an election period; and,
- Is entitled to Full Medicaid benefits as defined by the State of Idaho.

Furthermore,

- Molina does not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in MMCM Chapter 2.

Enrollment/Disenrollment Information

All Members of Molina Medicaid Medicare Coordinated Plan (HMO FIDE) and Molina Medicare Options (HMO) are full benefit dual eligible (e.g., they receive both Medicare and Medicaid. CMS rules state that these Members may enroll or disenroll throughout the year.

Members Toll-Free Telephone Numbers

Members may call our Member & Provider Contact Center local time, toll free at the telephone numbers listed below, or 711, for persons with hearing impairments (TTY/TDD).

- Medicare Options – (844) 560-9811
- MMCP – (844) 239-4913

Effective Date of Coverage

Molina will determine the effective date of enrollment for all enrollment requests. The effective date of coverage is determined when the complete enrollment is signed, received, following the Member's enrollment election period.

Disenrollment

Staff of Molina may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare Member to disenroll except when the Member has:

- Permanently moved outside Molina's service area.
- Lost Medicaid eligibility (for dual eligible enrolled in Molina MA Special Needs Plan.
- Lost Medicare Part A or B.

When Members permanently move out of Molina's service area or leave Molina's service area for over six (6) consecutive months, they must disenroll from Molina's programs. There are a number of ways that the Molina Membership Accounting Department may be informed that the Member has relocated:

- Out-of-area notification will be received from CMS on the Daily Transaction Reply Report (DTRR);
- The Member may call to advise Molina that they have permanently relocated; and/or,
- Other means of notification may be made through the Claims Department, if out-of-area claims are received with a residential address other than the one on file. (Molina does not offer a visitor/traveler program to Members).

Requested Disenrollment

Molina will process disenrollment of Members from the health plan only as allowed by CMS regulations. Molina will request that a Member be disenrolled under the following circumstances:

- Member requests disenrollment; (during a valid election period);
- Member enrolls in another plan (during a valid enrollment period);
- Member leaves the service area and directly notifies Molina Healthcare of the permanent change of residence;
- Member loses entitlement to Medicare Part A or Part B benefits;
- Member loses Medicaid eligibility;
- Molina loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina will send CMS-approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely, before the termination of the plan; and/or,
- Molina discontinues offering services in specific service areas where the Member resides.

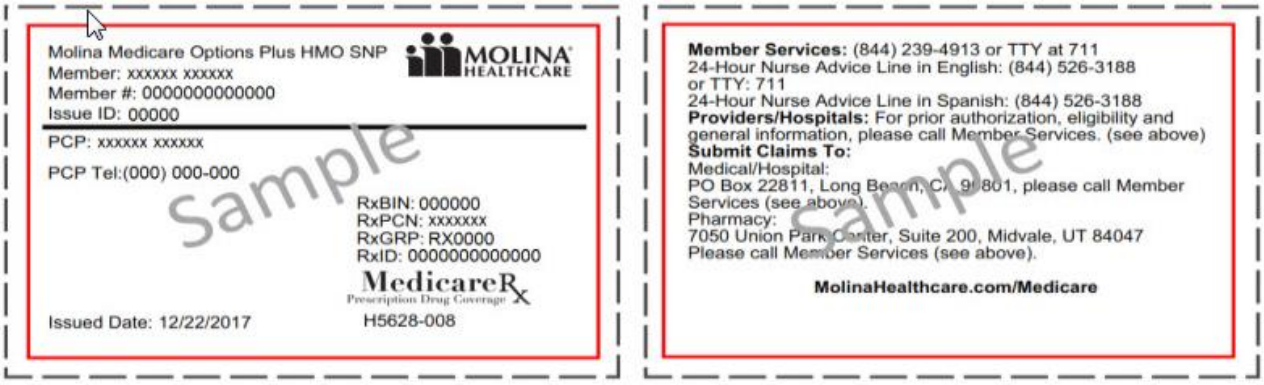
In all circumstances except death, Molina will provide a written notice to the Member with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS.

In the event of death, a verification of disenrollment will be sent to the deceased Member's estate.

Member Identification Card Example – Medical Services

Medicare Options

MMCP:



Verifying Eligibility

To ensure payment, Molina strongly encourages Providers to verify eligibility at every visit and especially prior to providing services that require authorization. Possession of the ID card does not guarantee Member eligibility or coverage. It is the responsibility of the Provider to verify the eligibility of the cardholder.

Dual Eligibles and Cost-Share

Molina allows Members to enroll who have all levels of Medicaid assistance. These Members may or may not be entitled to cost-share assistance, and may or may not have Medicaid benefits. Providers can find cost-share information on an individual Molina SNP Member through the Molina Provider Portal at www.MolinaHealthcare.com. Below is a cost-share chart to reference:

Cost Share Grid *Applies to all Molina Healthcare Medicare/Healthy Advantage plans.* ***Exception:*** *CA HMO D SNP, TX HMO D SNP and ID HMO FIDE SNP are $0 cost share plans*		
Type	**Medicare Parts A and B Cost-Share**	**Preventive**
QMB	0%	0%
QMB+	0%	0%
SLMB	20% *(Medicare Part A and B deductibles apply)*	0%
SLMB +	0% When service is covered by both Medicare and Medicaid Otherwise 20% *(Medicare Part A and B deductibles apply if 20%)*	0%
QI	20% *(Medicare Part A and B deductibles apply)*	0%
QDWI	20% *(Medicare Part A and B deductibles apply)*	0%
FBDE	0% When service is covered by both Medicare and Medicaid Otherwise 20% *(Medicare Part A and B deductibles apply if 20%)*	0%
00	20% *(Medicare Part A and B deductibles apply)*	0%
09	20% *(Medicare Part A and B deductibles apply)*	0%
99	Unknown; assess 0% at time of service, check back 2nd week of following month	0%

8. Benefit Overview

Questions about Molina Medicare Benefits

If there are questions as to whether a service is covered or requires prior authorization, please contact Molina's Member & Provider Contact Center toll free at (844) 560-9811, seven (7) days a week, from 8:00 a.m. to 8:00 p.m., local time, or (TTY/TDD) 711, for persons with hearing impairments.

Link to Summary of Benefits

Detailed information about plan premiums, benefits, copayments and coinsurance can be found in the Summary of Benefits booklet sent to each Molina Medicare Member. The following web links provide the Summary of Benefits.

- Molina Medicare Options (MMO)
  www.MolinaHealthcare.com/ID/MMO/Summary of Benefits
- Medicare Medicaid Coordinated Plan
  www.MolinaHealthcare.com/ID/MMCP/Summary of Benefits

Link to Evidence of Coverage

Detailed information about benefits and services can be found in the Evidence of Coverage booklets sent to each Molina Medicare Member. The following web links provide the Evidence of Coverage.

- Medicare Options HMO
  www.MolinaHealthcare.com/ID/MMO/EOC
- Medicare Medicaid Coordinated Plan
  www.MolinaHealthcare.com/ID/MMCP/EOC

Please note for **2019**: The Medicare-covered initial preventive and physical examination (IPPE) and the annual wellness visit are covered at zero cost sharing. Our plans cover Medicare-covered preventive services at no cost to the Member.

9. Healthcare Services (HCS)

Introduction

Molina provides care management services to 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 case 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 utilization 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 Utilization Management (UM) Department toll free at (844) 239-4913 for MMCP and (844) 560-9811 for Medicare Options. The UM Department fax number is (844) 251-1450.

Utilization Management (UM)

Molina's UM program ensures appropriate and effective utilization of services. The UM team works closely with the Case 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 health care services across the continuum of care
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs;
- 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;
- Implementing comprehensive processes to monitor and control the utilization of health care resources;
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness;
- Reviewing processes to ensure 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;
- Ensuring that UM decision tools are appropriately applied in determining Medical Necessity decision.
- Identify and assess the need for Case 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;
- 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; and,
- 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

Molina maintains a Utilization Management (UM) Department to work with Members and Providers in administering the Molina Utilization Management Program.

The address for mail requests is:

Molina Healthcare of Idaho, Inc.
Attn: Healthcare Services Dept.
7050 Union Park Center, Suite 200
Midvale, UT 84047

This Molina Provider Manual contains excerpts from Molina's Healthcare Services Program Description. For a complete copy of your state's Healthcare Services Program Description you can access the Molina website or contact the UM Department to receive a written copy. You can always find more information about Molina's UM including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer on Molina's website or by calling the UM Department.

Molina's UM Department is designed to provide comprehensive health care management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service. Molina works in partnership with Members and Providers to promote a seamless delivery of health care services. Molina's managed care programs balance a combination of benefit design, reimbursement structure, information analysis and feedback, consumer education, and active intervention that manages cost and improves quality. Molina maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina medical management program also ensures that Molina only reimburses for services identified as a covered benefit and medically necessary. Elements of the Molina medical management program include medical necessity review, prior authorization, inpatient management and restrictions on the use of non-network Providers.

Medical Groups/IPAs and delegated entities who assume responsibility for UM must adhere to Molina's UM Policies. Their programs, policies and supporting documentation are reviewed by Molina at least annually.

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.

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 customarily updated quarterly, but may be updated more frequently as appropriate, and the current documents are posted on the Molina website at www.MolinaHealthcare.com.

Requests for prior authorizations to the UM Department may be sent by telephone, fax, mail based on the urgency of the requested service, or via the Provider Web Portal. Contact telephone numbers, fax numbers and addresses are noted in the introduction of this section.

Providers are encouraged to use the Molina Prior Authorization Form provided on the Molina web site. If using a different form, the Provider is required to supply the following information, as applicable, for the requested service:

- Member demographic information (Name, DOB, ID #, etc.).
- Clinical information sufficient to document the Medical Necessity of the requested services.
- Provider demographic information (Referring provider and referred to Provider/facility).
- Requested service/procedure (including specific CPT/HCPCS and ICD-10 Codes).
- Location where the 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.

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. Prior Authorization is not a guarantee of payment. Payment is contingent upon Member eligibility at the time of service.

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the member's clinical situation. For expedited request for authorization, we make a determination as promptly as the member's health requires and no later than seventy-two (72) hours after we receive the initial request for service in the event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a member's life or health. For a standard authorization request, Molina makes the determination and provide within fourteen (14) calendar days.

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 (888) 665-1328.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider by telephone if at all possible or by fax with confirmation of receipt if telephonic communication fails.

Molina abides by CMS rules and regulations for all pre-service requests and will allow a Peer-to-Peer conversation in limited circumstances.

- While the request for an Organization Determination (service) is being reviewed but prior to a final determination being rendered.
- While an appeal of an Organizational Determination (service) is being reviewed.
- Before a determination has been made, if the Molina Medical Director believes that a discussion with the requesting physician would assist Molina in reaching a favorable determination (within the obligatory timeframes stated above for a standard or expedited request).

Medicare says that if Molina, being a Medicare Advantage plan, decides to not provide or pay for a requested service, in whole or in part, then an Adverse Organization Determination (denial) has occurred and we must issue a written denial notice. Once the notice has been mailed or faxed to you or the Member, or Molina has phoned the Member and/or you advising that there has been an Adverse Organization Determination (denial), the appeals process then becomes available to you.

If you wish to dispute Molina's Adverse Organization Determination (denial) we may only process the request by following the Standard or Expedited appeal process. This

means that if you contact Molina to request a Peer-to-Peer review, we will advise that you must follow the rules for requesting a Medicare appeal. Refer to the Complaints, Grievance and Appeals of this Provider Manual.

Requesting Prior Authorization

The most current Prior Authorization Guidelines and Prior Authorization Request Form can be found on the Molina website, www.MolinaHealthcare.com.

Provider Portal: Participating Providers are encouraged to use the Molina Provider Portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Molina Provider Portal. The benefits of submitting your prior authorization request through the Provider Portal are:

- Create and submit Prior Authorization Requests.
- Check status of Authorization Requests.
- Receive notification of change in status of Authorization Requests.
- Attach medical documentation required for timely medical review and decision making.

Fax: The Prior Authorization form can be faxed to Molina at: (844) 251-1450. If the request is not on the form provided by Molina, be sure to send to the attention of the Healthcare Services Department. Please indicate on the fax 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.** Please include the supporting documentation needed for Molina to make a determination along with the request to facilitate your request being made as expeditiously as possible.

Phone: Prior Authorizations can be initiated by contacting Molina's Healthcare Services Department at (888) 483-0760. It may be necessary to submit additional documentation before the authorization can be processed.

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

Molina Healthcare of Idaho, Inc.
Attn: Healthcare Services Dept.
7050 Union Park Center, Suite 200
Midvale, UT 84047

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.

Clinical Trials

For information on clinical trials, go to www.cms.hhs.gov or call (800) MEDICARE.

> Information Only: On September 19, 2000, the Health Care Financing Administration (HCFA) approved a National Coverage Policy that permits all Medicare Beneficiaries to participate in qualified clinical trials. For the initial implementation, Medicare will pay Providers and hospitals directly on a fee for service basis for covered clinical trial services for Members of Molina's Medicare plans and other Medicare HMO plans. The Provider and/or hospital conducting the clinical trial will submit all claims for clinical trial services directly to Medicare, not to the Medicare plan. This means the Member will be responsible for all Medicare fee for service deductibles and copayments for any services received as a participant in a clinical trial.

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 Practitioners

Molina HCS staff is accessible by calling (888) 483-0760 during normal business hours, Monday through Friday (except for Holidays) from 8:30 AM to 5:30 PM for information and authorization of care. When initiating, receiving or returning calls the HCS staff will identify the organization, their name and title.

Molina's Nurse Advice Line is available to Members and Providers twenty-four (24) hours a day, seven (7) days a week at (844) 526-3188. 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.

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 service); 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 UM requests that may lead to denial are reviewed by a health professional at Molina (medical director, pharmacy director, or appropriately licensed health professional).

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

The timelines and procedures are published in the Provider Manual and available on the www.MolinaHealthcare.com website.

In addition Molina's provider training includes information on the UM processes and Authorization requirements.

Hospitals

Emergency Services

Emergency Services means covered inpatient and outpatient services furnished by a provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

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. Retroactive authorization requests for services rendered will normally not be approved.

Inpatient Management

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 inpatient 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 investigational 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 apprised of service requests and of the service provided to the Member by other Providers.

Inpatient Review

Molina performs concurrent inpatient review to determine medical necessity and appropriateness of an inpatient stay. The goal of inpatient review is to authorize care, identify appropriate discharge planning needs and facilitate discharge to an appropriate setting. The criteria used to determine medical necessity will be as described in "Medical Necessity Review".
The inpatient review process assures the following:

- Members are correctly assigned to observation or inpatient status
- Services are timely and efficient;
- Comprehensive treatment plan is established;
- Member is not being discharged prematurely;
- Member is transferred to appropriate in-network hospital or alternate levels of care when clinically indicated;
- Effective discharge planning is implemented; and,
- Member appropriate for outpatient case management is identified and referred.

Molina follows payment guidelines for inpatient status determinations consistent with CMS guidelines, including the two (2) midnight and observation rules as outlined in the Medicare Benefit Policy Manual.

NOTICE Act

Under the NOTICE Act, hospitals and CAHs must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including an MA enrollee) who receives observation services as an outpatient for more than twenty-four (24) hours. See the final rule that went on display August 2, 2016 (published August 22, 2016) at: https://www.federalregister.gov/documents/2016/08/22/2016-18476

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.

Inpatient Facility Admission

Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. Proper notification is required by Molina on the day of admission to ensure timely and accurate payment of hospital claims. Delegated

Medical Groups/IPAs must have a clearly defined process that requires the hospital to notify Molina on a daily basis of all hospital admissions.

Notifications may be submitted by fax. Contact telephone numbers and fax numbers are noted in the introduction to the Utilization Management section of this Provider Manual.

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. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Molina Member or there was a Molina error, a medical necessity review will be performed. 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 requirements or Provider contracts that prohibit administrative denials supersede this policy.

Readmissions

Hospital readmissions less than thirty-one (31) calendar days from the date of discharge have been found by CMS to potentially constitute a quality of care problem. Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines, as well as Federal and State regulations.

Molina will conduct readmission reviews for applicable participating hospitals if both admissions occur at the same facility. If it is determined that the subsequent admission is related to the first admission (Readmission), the first payment may be considered as payment in full for both the first and second hospital admissions. Readmission reviews will be conducted in accordance with CMS guidelines.

Exceptions

1. The readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature discharge or inadequate discharge planning in the first admission necessitated the second admission.
2. The readmission is part of a Medically Necessary, prior authorized or staged treatment plan.
3. There is clear medical record documentation that the patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning.

Non-Network Providers and Services

Molina maintains a contracted network of qualified health care 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 Emergency Services as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations.

"Emergency Services" means covered inpatient and outpatient services furnished by a provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

Avoiding Conflict of Interest

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

Molina 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 Staff work 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. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

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.

There are two (2) main coordination of care processes for Molina Members. The first occurs when a new Member enrolls in Molina and needs to transition medical care to Molina contracted Providers. There are mechanisms within the enrollment process to identify those Members and reach out to them from the Member & Provider Contact Center (M&PCC) to assist in obtaining authorizations, transferring to contracted DME vendors, receiving approval for prescription medications, etc. The second coordination of care process occurs when a Molina Member's benefits will be ending and they need assistance in transitioning to other care. The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

Providers must offer the opportunity to provide assistance to identified Members through:

- Notification of community resources, local or state funded agencies;
- Education about alternative care; and
- How to obtain care as appropriate.

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.

For additional information regarding continuity of care and transition of Members, please contact Molina at (844) 239-4913.

UM Decisions

An organization determination 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 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; and
- Payment for any other health service furnished by a Provider that the Member believes is covered under Medicare or if not covered under Medicare, should have been furnished, arranged for or reimbursed by Molina Medicare or the delegated Medical Group/IPA or other delegated entity.

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 do not replace Medicare Coverage Determinations when making decisions regarding appropriate medical treatment for Molina Members. As a Medicare Plan, Molina and its delegated Medical Groups/IPAs, or other delegated entity at a minimum, cover all services and items required by Medicare.

Requests for authorization not meeting criteria must be reviewed by a designated Molina Medical Director or other 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.

1. **Standard Initial Organization Determinations (Pre-service) –** Standard initial organization determinations must be made as soon as medically indicated, within a maximum of fourteen (14) calendar days after receipt of the request. The table under number four (4) below describes the CMS required decision timeframes and notification requirements followed by Molina.

2. **Expedited Initial Organization Determinations –** A request for expedited determinations may be made. An organization determination is expedited if applying the standard determination timeframes could seriously jeopardize the life or health of the Member or the Member's ability to re-gain maximum function. Molina and any delegated Medical Group/IPA or other delegated entity is responsible to appropriately log and respond to requests for expedited initial organization determinations.
    - Expedited Initial Determinations must be made as soon as medically necessary, within seventy-two (72) hours (including weekends and holidays) following receipt of the validated request; and
    - Delegated Medical Groups/IPAs or other delegated entities are responsible for submitting a monthly log of all Expedited Initial Determinations to Molina's Delegation Oversight Department that lists pertinent information about the expedited determination including Member demographics, data and time of receipt and resolution of the issue, nature of the problem and other information deemed necessary by Molina or the Medical Group/IPA or other delegated entities. The table under number four (4) below describes the CMS required decision timeframes and notification requirements followed by Molina.

3. **Written Notification of Denial –** The Member must be provided with written notice of the determination, if the decision is to deny, in whole or in part, the requested service or payment. If the Member has an authorized representative, the representative must be sent a copy of the denial notice. The appropriate written notice, that has CMS approval, must be issued within established regulatory and certification timelines. The adverse organization determination templates shall be written in a manner that is understandable to the Member and shall provide the following:
   - The specific reason for the denial, including the precise criteria used to make the decision that takes into account the Member's presenting medical condition, disabilities and language requirements, if any;
   - Information regarding the Member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the Member's behalf;
   - Include a description of both the standard and expedited reconsideration process, timeframes and conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;
   - Payment denials shall include a description of the standard reconsideration process, timeframes and other elements of the appeal process; and
   - A statement disclosing the Member's right to submit additional evidence in writing or in person.
   - Failure to provide the Member with timely notice of an organization determination constitutes an adverse organization determination which may be appealed.

4. **Termination of Provider Services (SNF, HH, CORF)/Issuance of Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC) –** When a termination of authorized coverage of a Member's admission to a skilled nursing facility (SNF) or coverage of home health agencies (HHA) or comprehensive outpatient rehabilitation facility (CORF) services occurs, the Member must receive a written notice two (2) calendar days or two (2) visits prior to the proposed termination of services.

   Molina or the delegated Medical Group/IPA must coordinate with the SNF, HHA or CORF Provider to ensure timely delivery of the written notice, using the approved NOMNC. Delivery of the notice is not valid unless all elements are present and Member or authorized representative signs and dates the notice to document receipt.
   - The NOMNC must include the Member's name, delivery date, date that coverage of services ends and QIO information;
   - The NOMNC may be delivered earlier than two (2) days before coverage ends;
   - If coverage is expected to be fewer than two (2) days in duration, the NOMNC must be provided at the time of admission; and,

- If home health services are provided for a period of time exceeding two (2) days, the NOMNC must be provided on or before the second to last service date.

Molina (or the delegated entity) remains liable for continued services until two (2) days after the Member receives valid notice. If the Member does not agree that covered services should end, the Member may request a Fast Track Appeal by the Quality Improvement Organization (QIO) by noon of the day following receipt of the NOMNC, or by noon of the day before coverage ends.

Upon notification of the Member's request for the Fast Track Appeal, Molina (or the delegated entity) must provide a detailed notice to the Member and to the QIO no later than the close of business, using the approved DENC explaining why services are no longer necessary or covered. The DENC must include the following:

- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;
- A description of any applicable coverage rule, instruction or other policy, citations, or information about how the Member may obtain a copy of the policy from Molina or the delegated entity;
- Any applicable policy, contract provision or rationale upon which the termination decision was based; and
- Facts specific to the Member and relevant to the coverage determination that is sufficient to advise the Member of the applicability of the coverage rule or policy to the Member's case.

Reporting of Suspected Abuse and/or Neglect

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. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected in Idaho must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or child care givers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers.

Suspected abuse and/or neglect should be reported as follows:

Child Abuse:

Department of Health and Welfare
Website: healthandwelfare.idaho.gov
Phone: 855-552-5437
Adult Abuse:

Idaho Commission on Aging
Website: aging.idaho.gov
Phone: Please access the website above for specific county reporting phone numbers.

Molina's HCS teams 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 and Post-Stabilization Services

Emergency Services means covered inpatient and outpatient services furnished by a provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

Emergency Services are covered on a twenty-four (24) hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition.

Molina accomplishes this service by providing a twenty-four (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 contracts with vendors that provide twenty-four (24) hour Emergency Services for ambulance and hospitals.

Molina and its contracted Providers must provide emergency services and post-emergency stabilization and maintenance services to treat any Member with an Emergency Medical Condition in compliance with Federal Law. An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of

sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member including the health of a pregnant woman and/or her unborn child in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any body part; and/or
- Serious disfigurement.

Molina covers maintenance care and post-stabilization services which are medically necessary, non-emergency services. Molina or its delegated entity arranges for post-stabilization services to ensure that the patient remains stabilized from the time the treating hospital requests authorization until the time the patient is discharged or a contracting medical provider agrees to other arrangements.

Pre-approval of emergency services is not required. Molina requires the hospital emergency room to contact the Member's primary care Provider upon the Member's arrival at the emergency room. After stabilization of the Member, Molina requires pre-approval of further post-stabilization services by a participating Provider or other Molina representative. Failure to review and render a decision on the post-stabilization pre-approval request within one (1) hour of receipt of the call shall be deemed an authorization of the request.

Molina or its delegated entity is financially responsible for these services until Molina or its delegated entity becomes involved with managing or directing the Member's care.

Molina and its delegated entity provides urgently needed services for Members temporarily outside of the service area but within the United States or who have moved to another service area but are still enrolled with. Urgent Services are covered services that are medically necessary and are needed urgently, typically the same day or within two (2) days of onset of symptoms, as judged by a prudent layperson.

Primary Care Providers

Molina provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina. Molina's Medicare Members are required to see a PCP who is part of the Molina Medicare Network. Molina's Medicare Members may select or change their PCP by contacting Molina's Member & Provider Contact Center.

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Referrals from a Molina PCP are required for a Member to receive specialty services, however,

no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral services.

Molina will help to arrange specialty care outside the network when Providers are unavailable or the network is inadequate to meet a Member's medical needs. To obtain such assistance contact the Molina UM Department. Referrals to specialty care outside the network require prior authorization from Molina.

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.

Case Management

The Case Management Program provides care coordination and health education for disease management, as well as identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals. Case Management focuses on the delivery of quality, cost-effective, and appropriate health care services for Members with complex and chronic care needs. Members may receive health risk assessments that help identify medical, mental health and medication management problems to target highest-needs members who would benefit from assistance and education from a case manager. Additionally, functional, social support and health literacy deficits are assessed, as well as safety concerns and caregiver needs. To initiate the case management process, the Member is screened for appropriateness for case management program enrollment using specified criteria. Criteria are used for opening and closing cases appropriately with notification to Member and Provider.

1. **The role of the Case Manager includes:**
    - Coordination of quality and cost-effective services;
    - Appropriate application of benefits;
    - Promotion of early, intensive interventions in the least restrictive setting;
    - Assistance with transitions between care settings;
    - Provision of accurate and up-to-date information to Providers regarding completed health assessments and care plans;
    - Creation of individualized care plans, updated as the Member's health care needs change;
    - Facilitation of Interdisciplinary Care Team meetings;
    - Utilization of multidisciplinary clinical, behavioral and rehabilitative services;
    - Referral to and coordination of appropriate resources and support service, including Long Term Services & Supports;

- Attention to Member satisfaction;
- Attention to the handling of PHI and maintaining confidentiality;
- Provision of ongoing analysis and evaluation;
- Protection of Member rights; and
- Promotion of Member responsibility and self-management.

2. **Referral to Case Management may be made by any of the following entities:**
   - Member or Member's designated representative;
   - Member's primary care Provider;
   - Specialists;
   - Hospital Staff;
   - Home Health Staff; and
   - Molina staff.

Molina Special Needs Plan Model of Care

Note: Model of Care Enhancements do not apply to standard MAPD programs.

1. **Targeted Population –** Molina operates Medicare Dual Eligible Special Needs Plans (SNP) for Members who are fully eligible for both Medicare and Medicaid. In accordance with CMS regulations, Molina has a SNP Model of Care that outlines Molina's efforts to meet the needs of the dual eligible SNP members. This population has a higher burden of multiple chronic illnesses and sub-populations of frail/disabled Members than other Medicare Managed Care Plan types. The Molina Dual Eligible Special Needs Plan Model of Care addresses the needs of all sub-populations found in the Molina Medicare SNP.

2. **Care Management Goals –** Utilization of the Molina SNP extensive network of primary Providers, specialty Providers and facilities, in addition to services from the Molina Medicare SNP Interdisciplinary Care Team (ICT), will improve access of Molina Members to essential services such as medical, mental health and social services. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:

a. Molina Geo Access reports showing availability of services by geographic area;

b. Number of Molina SNP Members utilizing the following services:
   - Primary Care Provider (PCP) Services
   - Specialty (including Mental/Behavioral Health) Services
   - Inpatient Hospital Services
   - Skilled Nursing Facility Services
   - Home Health Services
   - Mental/Behavioral Health Facility Services
   - Durable Medical Equipment Services

- Emergency Department Services
- Supplemental transportation benefits
- Long Term Services and Supports

c. HEDIS® use of services reports;
d. Member Access Complaint Report;
e. Medicare CAHPS® Survey; and
f. Molina Provider Access Survey.

3. Members of the Molina SNP will have access to quality affordable health care. Since Members of the Molina SNP are full dual eligible for Medicare and Medicaid they are not subject to out of pocket costs or cost sharing for covered services. Molina focuses on delivering high quality care. Molina has an extensive process for credentialing network Providers, ongoing monitoring of network Providers and peer review for quality of care complaints. Molina maintains recommended clinical practice guidelines that are evidence based and nationally recognized. Molina regularly measures Provider adherence to key provisions of its clinical practice guidelines. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:

a. HEDIS® report of percent Providers maintaining board certification;
b. Serious reportable adverse events report;
c. Annual report on quality of care complaints and peer reviews;
d. Annual PCP medical record review;
e. Clinical Practice Guideline Measurement Report;
f. Licensure sanction report review; and
g. Medicare/Medicaid sanctions report review.

4. By having access to Molina's network of primary care and specialty Providers as well as Molina's programs that include Care Management Service Coordination, Nurse Advice Line, Utilization Management and Quality Improvement, SNP Members have an opportunity to realize improved health outcomes.

Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:

a. Medicare HOS; and,
b. Chronic Care Improvement Program Reports.

5. Molina Members will have an assigned point of contact for their coordination of care. According to Member's need, this coordination of care contact point might be their Molina Network PCP or Molina Case Manager. Care will be coordinated through a single point of contact who interact with the ICT to coordinate services as needed.

6. **Members of the Molina Medicare SNP will have improved transitions of care across health care settings, Providers and health services.** The Molina Medicare SNP has programs designed to improve transitions of care. Authorization processes enable Molina staff to become aware of transitions of care due to changes in health care status as they occur. Molina case managers work with Members, their caregivers and their Providers to assist in care transitions. In addition Molina has a program to provide follow-up telephone calls or face to face visits to Members while the Member is in the hospital and after hospital discharge to make sure that they received and are following an adequate discharge plan. The purpose is to establish a safe discharge plan and to evaluate if the Members are following the prescribed discharge plan once they are home, have scheduled a follow up physician appointment, have filled all prescriptions, understand how to administer their medications and have received the necessary discharge services such as home care or physical therapy. All Members experiencing transition receive a post discharge educational letter advising them of benefits and services offered by Molina. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:
   a. Transition of Care Data;
   b. Re-admission within thirty (30) Days Report;
   c. Provider adherence to notification requirements; and,
   d. Provider adherence to provision of the discharge plan.

7. **Members of the Molina Medicare SNP will have improved access to preventive health services.** The Molina Medicare SNP expands the Medicare preventive health benefit by providing annual preventive care visits at no cost to all Members. This allows PCPs to coordinate preventive care on a regular basis. Molina uses and publicizes nationally recognized preventive health schedules to its Providers. Molina also makes outreach calls to Members to remind them of overdue preventive services and to offer assistance with arranging appointments and providing transportation to preventive care appointments.

   Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks: HEDIS® Preventive Services Reports.

8. **Members of the Molina Medicare SNP will have appropriate utilization of health care services**. Molina utilizes its Utilization Management team to review appropriateness of requests for health care services using appropriate Medicare criteria and to assist in Members receiving appropriate health care services in a timely fashion from the proper Provider.

Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks: Molina Over and Under Utilization Reports.

9. Staff Structure and Roles - The Molina Medicare SNP has developed its staff structure and roles to meet the needs of dual eligible Special Needs Plan Members. Molina's background as a provider of Medicaid Managed Care services in the states that it serves allows the plan to have expertise in both the Medicare and Medicaid benefits that Members have access to in the Molina Medicare Dual Eligible SNP. Molina has many years of experience managing this population of patients within Medicaid to go with its experience of managing the Medicare part of their benefit. Molina's Member advocacy and service philosophy is designed and administered to assure Members receive value-added coordination of health care and services that ensures continuity and efficiency and that produces optimal outcomes. Molina employed staff are organized in a manner to meet this objective and include:

a. **Care Management Team** that forms a main component of the interdisciplinary care team (ICT) comprised of the following positions and roles:
   i. Care Review Processors – Gather clinical information about transitions in care and authorizations for services, authorize services within their scope of training and job parameters based upon predetermined criteria, serve as a resource for nursing staff in collecting existing clinical information to assist nursing assessments and care team coordination.
   ii. Care Review Clinicians (LPN/RN) – Assess, authorize, coordinate and evaluate services, including those provided by specialists and therapists, in conjunction with the Member, Providers and other team members based on Member's needs, medical necessity and predetermined criteria.
   iii. Case Managers (CM) (nurse, social workers, Behavioral Health professionals) – Work with the IRC and Transition Coaches to support members after the thirty (30) day transition period by assessing, authorizing, coordinating, triaging and evaluating services in conjunction with the Member, Providers and other team members based on Member's needs and preferences. The CM supports Members, caregivers and Providers in Member transitions between care settings including facilitation of information retrieval from ancillary Providers, consultants, and diagnostic studies for development, implementation and /or revision of the integrated care plan. The CM continues to work with the Member to identify and address issues regarding Member's medical, behavioral health, LTSS and social needs and maintains and updates the integrated

care plan and assists in the coordination of needed services. Updates to the ICP are communicated by the CM to the Member and participants of the ICT based on member preference.

iv. Health Manager – Develop materials for Health Management programs. Serve as resource for Members and Molina staff members regarding Health Management Program information, educates Members on how to manage their condition.

v. Transitions of Care Coach (Medical and Behavioral Health Clinicians) – The Transitions Coach is notified by and works closely with the IRC and functions as a facilitator of interdisciplinary collaboration across the transition, engaging the Member and family caregivers, facility and Providers to participate in the formation and implementation of an individualized plan of care including interventions to mitigate the risk of re-hospitalization. The primary role of the Transitions staff is to follow the Member closely for thirty (30) days post discharge to ensure a safe transition to the least restrictive most inclusive setting of the Member's choice and to encourage self-management and direct communication between the Member and Provider.

vi. Community Connectors/Health Workers – the Community Connectors are community health workers trained by Molina to serve as Member navigators and promote health within their own communities by providing education, advocacy and social support. Community Connectors also help Members navigate the community resources and decrease identified barriers to care.

vii. Behavioral Health Team includes Molina employed clinical behavioral health specialists to assist in behavioral health care issues. A board certified Psychiatrist functions as a Behavioral Health Medical Director and as a resource for the Integrated Care Management and Utilization Management Teams and providers regarding Member's behavioral health care needs and care plans.

b. **Member & Provider Contact Center** – Serves as a Member's initial point of contact with Molina and main source of information about utilizing the Molina Medicare SNP benefits and is comprised of the following positions:

i. Member Services Representative – Initial point of contact to answer Member questions, assist with benefit information and interpretation, provide information on rights and responsibilities, assist with PCP selection, advocate on Members' behalf, assist Members with interpretive/translation services, inform and educate Members on available services and benefits, act as liaison in directing calls to other departments when necessary to assist Members.

ii. Member Services Managers/Directors – Provide oversight for member services programs, provide and interpret reporting on

member services functions, evaluate member services department functions, identify and address opportunities for improvement.

c. **Appeals and Grievances Team** that assists Members with information about and processing of appeals and grievances:
   i. Appeals and Grievances Coordinator – Provide Member with information about appeal and grievance processes, assist Members in processing appeals and grievances, notifies Members of appeals and grievance outcomes in compliance with CMS regulations.
   ii. Appeals and Grievances Manager – Provide oversight of appeals and grievance processes assuring that CMS regulations are followed, provide and interpret reporting on A&G functions, evaluate A&G department functions, identify and address opportunities for improvement.

d. **Quality Improvement Team** that develops, monitors, evaluates and improves the Molina Medicare SNP Quality Improvement Program. QI Team is comprised of the following positions:
   i. QI Specialist – Coordinate implementation of QI Program, gather information for QI Program reporting and evaluations, provide analysis of QI Program components.
   ii. QI Managers/Directors – Development and oversight of QI Program which includes program reporting and evaluation to identify and address opportunities for improvement.
   iii. HEDIS® Specialist – Gather and validate data for HEDIS® reporting.
   iv. HEDIS® Manager – Oversight and coordination of data gathering and validation for HEDIS® reporting, provide and interpret HEDIS® reports, provide preventive services missing services report.

e. **Medical Director Team** has employed board-certified physicians. Medical Directors and Healthcare Services Program Manager - Responsible for oversight of the development, training and integrity of Molina's Medicare SNP Healthcare Services and Quality Improvement programs. Resource for Integrated Care Management and Care Access and Monitoring Teams and providers regarding Member's health care needs and care plans. Selects and monitors usage of nationally recognized medical necessity criteria, preventive health guidelines and clinical practice guidelines.

f. **Behavioral Health Team** has Molina employed health specialists to assist in behavioral health care issues:
   i. Psychiatrist Medical Director – Responsible for oversight of the development and integrity of behavioral health aspects of Molina's Medicare SNP Healthcare Services and Quality Improvement programs. Resource for Integrated Care Management and

Utilization Management Teams and Providers regarding Member's behavioral health care needs and care plans. Develops and monitors usage of behavioral health related medical necessity criteria and clinical practice guidelines.

g. **Pharmacy Team** has employed pharmacy professionals that administer the Part D benefit and assist in administration of Part B pharmacy benefits.
   i. Pharmacy Technician – Serves as point of contact for Members with questions about medications, pharmacy processes, and pharmacy appeals and grievances.
   ii. Pharmacist – Provide authorizations for Part D medications. Provide oversight of pharmacy technician performance, resource for Care Management Teams, other Molina staff and Providers, provide review of post discharge medication changes, review Member medication lists and report data to assure adherence and safety, interact with Members and Providers to discuss medication lists and adherence.

h. **Healthcare Analytics Team**
   i. Healthcare Analysts – Assist in gathering information, developing reports, providing analysis for health plan to meet CMS reporting requirements, evaluate the model of care and review operations.
   ii. Director Healthcare Analytics – Develop predictive modeling programs used to assist in identifying Members at risk for future utilization, oversight of health care reporting and analysis program, oversight of clinical aspects of Part C Quality Reporting, oversight of health care analysts.

i. **Health Management Team** is a Molina care team that provides multiple services to Molina's Medicare SNP Members. This team provides population based Health Management Programs for low risk Members identified with asthma and depression. The Health Management team also provides a twenty-four/seven (24/7) Nurse Advice Line for Members, outbound post hospital discharge calls and outbound preventive services reminder calls. The Health Management team is comprised of the following positions:
   i. Medicare Member Outreach Assistant – Make outbound calls related to gathering and giving information regarding Health Management programs, make outbound calls to review whether Member received hospital discharge plan, make referrals to Care/Case Managers when Members have questions about their hospital discharge plan, make outbound preventive service reminder calls.

ii. Nurse Advice Line Nurse – Receive inbound calls from Members and Providers with questions about medical care and after-hours issues that need to be addressed, give protocol based medical advice to Members, direct after-hours transitions in care.

j. **Interdisciplinary Care Team**

i. Composition of the Interdisciplinary Care Team: ICT members are determined by Member preferences and inclusion decisions are made collaboratively and with respect to the Member's right to self-direct care. Family Members and caregiver participation is encouraged and promoted, with the Member's permission. Members are educated during the assessment process on how to access the ICT and the Case Manager provides invitations either verbally or in writing to scheduled ICT meetings. The Member can opt out of the care team and/or choose to limit the role of their caregivers, or any other Provider or members of the care team.

The ICT is typically composed of:

- Member
- Care Giver
- PCP, Nurse Practitioner (NP), Physician Assistant (PA)
- Primary specialty physician
- Case Manager
- Molina Medical Director
- Molina Social worker
- Molina Behavioral health staff
- Molina Pharmacist

Additional members of the ICT may be added on a case-by-case basis depending on a Member's conditions/health status, health risk assessment results and ICP and Member preference:

- Molina Transitions staff
- Hospitalist
- Molina Community Connectors
- Network Medical Specialty Providers
- Network Home Health Providers
- Network or County Behavioral Health Providers
- Case Managers from County Agencies
- LTSS facility or HCBS staff
- Acute Care Hospital Staff
- Skilled Nursing Facility Staff
- Long Term Acute Care Facility Staff
- Certified Outpatient Rehabilitation Staff
- Behavioral Health Facility Staff

- Renal Dialysis Center Staff
- Out of Network Providers or Facility Staff (until a member's condition of the state of the Molina Network allows safe transfer to network care)

ii. Adding Members to the ICT will be considered when:
- The Member makes such a request.
- Member is undergoing a transition in healthcare setting.
- Member sees multiple medical specialists for care on a regular and ongoing basis.
- Member has significant complex or unresolved medical diagnoses identified in the member's health risk assessments.
- Member has significant complex or unresolved mental health or chemical dependency diagnoses.
- Member has significant complex or unresolved pharmacy needs.
- Is indicated by health risk assessment or ICP.

iii. Molina's Medicare SNP Members and their caregivers participate in the Molina ICT through many mechanisms including:
- Formal, scheduled, meetings with Molina case managers, physicians, pharmacists, social workers and Behavioral Health staff including the PCP and other external Providers of the Member's choosing.
- Participation in external vendor case review such as home health or nursing home case rounds.
- Molina staff accompanying the Member to their physician or treatment appointments.
- Three (3) way discussions with the Member, Molina staff, and any external Provider of home services.
- Discussions about their health care with their PCP.
- Discussions about their health care with medical specialists or ancillary Providers who are participating in the Member's care as directed by the Member's PCP.
- Discussions about their health care with facility staff who are participating in the Member's care as directed by the Member's PCP.
- During the assessment process by Molina Staff.
- Discussions about their health care with their assigned Molina Integrated Care Management Team members.
- Discussions with Molina Staff in the course of Health Management programs, preventive health care outreach, Care Transitions program and other post hospital discharge outreach.
- Discussion with Molina Pharmacists about complex medication issues.
- Through the appeals and grievance processes.

- By invitation during case conferences or regular ICT meetings.
- By request of the Member or caregiver to participate in regular ICT meetings.

iv. ICT Operations and Communication: The Molina Medicare SNP Member's assigned PCP and the Molina Integrated Care Management Team will provide the majority of the Integrated Care Management in the ICT. The Member's assigned PCP will be a primary source of assessment information, care plan development and Member interaction within the ICT. The PCP will regularly (frequency depends on the Member's medical conditions and status) assess the Member's medical conditions, develop appropriate care plans, request consultations, evaluations and care from other Providers both within and, when necessary, outside the Molina Network. The Molina Integrated Care Management Team will also provide assessments, care plan development and individualized care goals.

v. The Integrated Care Management Team will be primarily involved during assessment periods, individualized care plan follow-up, transitions of care settings, routine case management follow-up, and significant changes in the Member's health status. In addition, the Care management team will be involved after referral from other Molina Staff (i.e., Utilization Management staff, Pharmacists), requests for assistance from PCPs, requests for assistance from Members/caregivers. Transitions in care and significant changes in health status that need follow-up will be detected when services requiring prior authorization are requested by the Member's PCP or other Providers (signaling a transition in care or complex medical need). The PCP and Integrated Care Management Team will decide when additional ICT meetings are necessary and will schedule them on "as needed" basis.

vi. The ICT will hold regular case conferences for Members with complex health care needs and/or complex transition issues. Members will be chosen for case conferences based on need as identified by the Molina Integrated Care Management Team, when referred by their Provider or at the request of the Member/caregiver. All members of the ICT will be invited to participate in the case conference. Members and/or their caregivers will be invited to participate when feasible. The Molina CM will provide a case conference summary for each Member case discussed. The summary is then reviewed with the Member to ensure that he/she is comfortable with the plan of care. The Care Plan is updated with the Member agreement based on the case conference recommendations to align with Providers' treatment plans. Case conference summaries will be provided to all

applicable ICT members as determined by the Member or their representative upon request.

vii. Communication between ICT members will be compliant with all applicable HIPAA regulations and will occur in multiple ways including:

- The Molina CM may facilitate sharing of Member's health and LTSS records from ICT Providers before, during, and after transitions in care and during significant changes in the health status of Members, for those health services that require prior authorization, or during the course of regular case management activities
- Through consultations among those involved in the Member's care, which include as warranted county BH Case Managers, social workers, psychiatrists, home health workers, PCPs, Molina medical directors, pharmacists, dieticians, medical specialists, LTSS Providers and agencies, family members, and other caregivers
- Case conference summaries available to all Members and active members of the ICT based on Member preference.
- Updated ICPs are reviewed and shared with members of the ICT as often as determined by regulatory requirements, with significant changes in health status, or at minimum annually by clinical Molina staff in conjunction with annual Health Risk Assessments.
- Additional opportunities for review and revision of care plans may exist when ICT members become aware of member transitions in health care settings or significant changes in Member health care status.

10. Provider Network - The Molina Medicare SNP maintains a network of Providers and facilities that has a special expertise in the care of Dual Eligible Special Needs Plans Members. The population served in Dual Eligible Special Needs Plans has a disproportionate share of physical and mental/behavioral health disabilities. Molina's network is designed to provide access to medical care for the Molina Medicare SNP population.

The Molina Medicare SNP Network has facilities with special expertise to care for its SNP Members including:

- Acute Care Hospitals
- Long Term Acute Care Facilities
- Skilled Nursing Facilities
- Rehabilitation Facilities (Outpatient and Inpatient)
- Mental/Behavioral Health/Substance Abuse Inpatient Facilities
- Mental/Behavioral Health/Substance Abuse Outpatient Facilities

- Outpatient Surgery Centers (Hospital-based and Freestanding)
- Laboratory Facilities (Hospital-based and Freestanding)
- Radiology Imaging Centers (Hospital-based and Freestanding)
- Renal Dialysis Centers
- Emergency Departments (Hospital-based)
- Urgent Care Centers (Hospital-based and Freestanding)
- Diabetes Education Centers (Hospital-based)

The Molina Medicare SNP has a large community based network of medical and ancillary Providers with many having special expertise to care for the unique needs of its SNP Members including:

- Primary Care Providers – Internal Medicine, Family Medicine, Geriatric
- Medical Specialists (all medical specialties) including specifically Orthopedics, Neurology, Physical Medicine and Rehabilitation, Cardiology, Gastroenterology, Pulmonology, Nephrology, Rheumatology, Radiology and General Surgery.
- Mental/Behavioral Health Providers – Psychiatry, clinical psychology, Masters or above level licensed clinical social work, certified substance abuse specialist.
- Ancillary Providers – Physical therapists, occupational therapists, speech/ language pathology, chiropractic, podiatry.
- Nursing professionals – Registered nurses, nurse providers, nurse educators.

Molina determines Provider and facility licensure and competence through the credentialing process. Molina has a rigorous credentialing process for all providers and facilities that must be passed in order to join the Molina Medicare SNP Network. The Molina Credentialing Team gathers information and performs primary source verification (when appropriate) of training, active licensure, board certification, appropriate facility accreditation (JCAHO or state), malpractice coverage, malpractice history (National Practitioner Data Bank reports), Medicare opt out status, Medicare/Medicaid sanctions, state licensure sanctions.

After credentialing information file is complete and primary source verification obtained the Provider or facility is presented to the Molina Professional Review Committee (PRC). The PRC consists of Molina Network physicians who are in active practice as well as Molina Medical Directors. The PRC decides on granting network participation status to Providers who have gone through the credentialing process based on criteria including active licensure, board certification (may be waived to assure Member access when there is geographic need or access problems), freedom from sanctions and freedom from an excessive malpractice case history. Providers and facilities that have passed initial credentialing must go through a re-credentialing process every three (3) years utilizing the same criteria as the initial credentialing process. In addition the PRC performs ongoing monitoring for licensure status, sanctions, Medicare opt

out status, Member complaint reports and peer review actions on a monthly basis (or quarterly for some reporting).

The Member's PCP is primarily responsible for determining what medical services a Member needs. For Members receiving treatment primarily through specialist physician, the specialist may be primarily responsible for determining needed medical services. The PCP is assisted by the Molina Care Management Team, medical specialty consultants, ancillary Providers, mental/behavioral health Providers and Members or their caregivers in making these determinations. For Members undergoing transitions in health care settings, facility staff (hospital, SNF, home health, etc.) may also be involved in making recommendations or assisting with access to needed services. For those services that require prior authorization the Molina Care Management Team will assist Providers and Members in determining medical necessity, available network resources (and out of network resources where necessary). The Molina Care Management portion of the ICT will assist in finding access when difficulties arise for certain services.

A primary way that the Molina Provider Network coordinates with the ICT is via the Molina Medicare SNP Prior Authorization process. Molina's Medicare SNP Prior Authorization requirements have been designed to identify Members who are experiencing transitions in health care settings or have complex or unresolved health care needs. Molina Members undergoing transitions in health care settings or experiencing complex or unresolved health care issues usually require services that are prior authorized. This allows Members of the ICT to be made aware of the need for services and any changes in the Member's health status. Part of the process includes obtaining medical records and documenting in QNXT so that the ICT can track those changes. The Provider network will also communicate with the ICT when invited to attend ICT meetings, on an as needed basis by contacting the PCP or the Molina Care Management Team. Molina's electronic fax system allows for the transition of information from one Provider to another during transitions. Hospital inpatient information is provided to the PCP and/or treating Provider.

The Molina Medicare SNP will assure that specialized services are delivered in a timely and quality way by the following:

- Assuring that services requiring prior authorization are processed and that notification is sent as soon as required by the Member's health but no later than timelines outlined in CMS regulations.
- Directing care to credentialed network Providers when appropriate.
- Monitoring access to care reports and grievance reports regarding timely or quality care.

Reports on services delivered will be maintained by the ICT primarily in the PCP medical record. The Molina Medicare SNP regularly audits the completeness of

PCP medical records utilizing the annual PCP Medical Record Review process. The Molina Care Management Team will document relevant clinical notes on services and outcomes in QNXT and Clinical Care Advance platforms as appropriate to document significant changes in the Member's health care status or health care setting and to update care plans. A copy of the care plan will be provided to the PCP.

The Molina Medicare SNP ICT will be responsible for coordinating service delivery across care settings and Providers. The Member's assigned PCP will be responsible for initiating most transitions of care settings (e.g., hospital or SNF admissions) and referrals to specialty or ancillary Providers. The Molina Care Management Team will assist specifically with Prior Authorization, access issues and coordinating movement from one care setting to the next when Members experience a change in their health care status (e.g., hospital discharge planning).

The Molina Medicare SNP will use nationally recognized, evidence based clinical practice guidelines. Molina Medical Directors will select clinical practice guidelines that are relevant to the SNP population. These clinical practice guidelines will be communicated to Providers utilizing Provider newsletter and the Molina website. Molina will annually measure Provider compliance with important aspects of the clinical practice guidelines and report results to Providers.

11. Model of Care Training - The Molina Medicare SNP will provide initial and annual SNP Model of Care training to all employed and contracted personnel. Web based or in person Model of Care training will be offered initially to all Molina employees who have not completed such training and to all new employees. Verification of employee training will be through attendance logs for in person training or certificate of completion of web based training program.

All Molina Providers have access to SNP Model of Care training via the Molina website. Providers may also participate in webinar or in person training sessions on the SNP Model of Care. Molina will issue a written request to Providers to participate in Model of Care training. Due to the very large community based network of Providers and their participation in multiple Medicare SNPs it is anticipated that many Providers will not accept the invitation to complete training. The Molina Provider Services Department will identify key groups that have large numbers of Molina's Medicare SNP Members and will conduct specific in person trainings with those groups. The development of model of care training materials will be the responsibility of a designated Molina Services Program Director or Medical Director. Implementation and oversight of completion of training will be the responsibility of a designated Molina Compliance staff (employees) and a designated Molina Provider Services staff (Providers). Employees will be required to complete training or undergo

disciplinary action in accordance with Molina policies on completion of required training.

12. Communication - Molina will monitor and coordinate care for Members using an integrated communication system between Members/caregivers, the Molina ICT, other Molina staff, Providers and CMS. Communications structure includes the following elements:

a. Molina utilizes state of the art telephonic communications systems for telephonic interaction between Molina staff and all other stakeholders with capabilities for call center queues, call center reporting, computer screen sharing (available only to Molina staff) and audio conferencing. Molina maintains Member and Provider services call centers during CMS mandated business hours and a Nurse Advice Line (after hours) that Members and Providers may use for communication and inquiries. Interactive voice response systems may be used for Member assessment data gathering as well as general health care reminders. Electronic fax capability and Molina's ePortal allow for the electronic transmission of data for authorization purposes and transitions between settings. Faxed and electronic information is maintained in the Member's Molina record.

b. For communication of a general nature Molina uses newsletters (Provider and Member), the Molina website and blast fax communications (Providers only). Molina may also use secure web based interfaces for Member assessment, staff training, Provider inquiries and Provider training.

c. For communication between Members of the ICT, Molina has available audio conferencing and audio video conferencing (Molina staff only). Most regular and ad-hoc ICT care management meetings will be held on a face-to-face basis with PCPs, other Providers and Member/caregivers joining via audio conferencing as needed.

d. Written and fax documentation from Members and Providers (clinical records, appeals, grievances) when received will be routed through secure mail room procedures to appropriate parties for tracking and resolution.

e. Email communication may be exchanged with Providers and CMS.

f. Direct person-to-person communication may also occur between various stakeholders and Molina.

g. Molina Quality Improvement Committees (and Sub-Committees, as applicable) will meet regularly on a face-to-face basis with Committee Members not able to attend in person attending via audio conferencing.

Tracking and documentation of communications occurs utilizing the following:

a. The QNXT call tracking system will be used to document all significant telephonic conversations regarding inquiries from Members/caregivers and Providers. All telephonically received grievances will be documented in the QNXT call tracking system. QNXT call tracking allows storage of a record of inquiries and grievances, status reporting and outcomes reporting.

b. Communication between ICT Members and/or stakeholders will be documented in QNXT call tracking, QNXT clinical modules or Case Management documentation electronic platform as appropriate. This documentation allows electronic status tracking and archiving of discussions. Written meeting summaries may be used when issues discussed are not easily documented using the electronic means documented above.

c. Written and faxed communications when received are stored in an electronic document storage solution and archived to preserve the data. Written documents related to appeals and grievances result in a call tracking entry made in QNXT call tracking when they are received allowing electronic tracking of status and resolution.

d. Email communication with stakeholders is archived in the Molina email server.

e. Direct person-to-person communication will result in a QNXT call tracking entry or a written summary depending on the situation.

f. Molina Committee meetings will result in official meeting minutes which will be archived for future reference.

A designated Molina Quality Improvement Director (or leader) will have responsibility to oversee, monitor and evaluate the effectiveness of the Molina Medicare SNP Communication Program.

13. Performance and Health Outcomes Measurement - Molina collects, analyzes reports and acts on data evaluating the Model of Care. To evaluate the Model of Care, Molina may collect data from multiple sources including:

a. Administrative systems (demographics, call center data)
b. Authorizations
c. CAHPS®
d. Call Tracking
e. Claims
f. Clinical Care Advance (Care/Case/Disease Management Program data)

g. Encounters
h. HEDIS®
i. HOS
j. Medical Record Reviews
k. Pharmacy
l. Provider Access Survey
m. Provider Satisfaction Survey
n. Risk Assessments
o. Utilization
p. Chronic Disease Self-Management Plan (CDSMP) Assessment Results
q. Case Management Satisfaction Survey

Molina will use internal Quality Improvement Specialists, External Survey Vendors and Healthcare Analysts to collect analyze and report on the above data using manual and electronic analysis. Data analyzed and reported on will demonstrate the following:

a. Improved Member access to services and benefits.
b. Improved health status.
c. Adequate service delivery processes.
d. Use of evidence based clinical practice guidelines for management of chronic conditions.
e. Participation by Members/caregivers and ICT Members in care planning.
f. Utilization of supplementary benefits.
g. Member use of communication mechanisms.
h. Satisfaction with Molina's Case Management Program.

Molina will submit CMS required public reporting data including:

a. HEDIS® Data
b. SNP Structure and Process Measures
c. Health Outcomes Survey
d. CAHPS® Survey

Molina will submit CMS required reporting data including some of the following:

a. Audits of health information for accuracy and appropriateness.
b. Member/caregiver education for frequency and appropriateness.
c. Clinical outcomes.
d. Mental/Behavioral health/psychiatric services utilization rates.
e. Complaints, grievances, services and benefits denials.
f. Disease management indicators.
g. Disease management referrals for timeliness and appropriateness.
h. Emergency room utilization rates.
i. Enrollment/disenrollment rates.
j. Evidence-based clinical guidelines or protocols utilization rates.
k. Fall and injury occurrences.
l. Facilitation of Member developing advance directives/health proxy.

m. Functional/ADLs status/deficits.
n. Home meal delivery service utilization rates.
o. Hospice referral and utilization rates.
p. Hospital admissions/readmissions.
q. Hospital discharge outreach and follow-up rates.
r. Immunization rates.
s. Medication compliance/utilization rates.
t. Medication errors/adverse drug events.
u. Medication therapy management effectiveness.
v. Mortality reviews.
w. Pain and symptoms management effectiveness.
x. Policies and procedures for effectiveness and staff compliance.
y. Preventive programs utilization rates (e.g., smoking cessation).
z. Preventive screening rates.
aa. Primary care visit utilization rates.
bb. Satisfaction surveys for Members/caregivers.
cc. Satisfaction surveys for Provider network.
dd. Screening for depression and drug/alcohol abuse.
ee. Screening for elder/physical/sexual abuse.
ff. Skilled nursing facility placement/readmission rates.
gg. Skilled nursing facility level of care Members living in the community having admissions/readmissions to skilled nursing facilities.
hh. Urinary incontinence rates.
ii. Wellness program utilization rates.

Molina will use the above data collection, analysis and reporting to develop a comprehensive evaluation of the effectiveness of the Molina Model of Care. The evaluation will include identifying and acting on opportunities to improve the program. A designated Molina Quality Improvement Director and/or Medical Director will have responsibility for monitoring and evaluating the Molina SNP Model of Care. Molina will notify stakeholders of improvements to the Model of Care by posting the Model of Care Evaluation on its website.

14. Care Management for the Most Vulnerable Subpopulations - The Molina SNP will identify vulnerable sub-populations including frail/disabled, multiple chronic conditions, End Stage Renal Disease (ESRD) and those nearing end of life by the following mechanisms:
a. Risk assessments;
b. Home visits;
c. Predictive modeling;
d. Claims data;
e. Pharmacy data;
f. Care/case/disease management activities;
g. Self-referrals by Members/caregivers;

h. Referrals from Member Services; and/or
i. Referrals from Providers.

Specific add-on services of most use to vulnerable sub-populations include:
a. Case management;
b. Disease management; and/or
c. Provider home visits.

The needs of the most vulnerable population will be met within the Molina SNP Model of Care by early identification and higher stratification/priority in Molina programs including Disease Management and Case Management. These Members will be managed more aggressively and more frequently by the ICT. This will assure that they are receiving all necessary services and that they have adequate care plans before, during and after transitions in health care settings or changes in health care status.

10. Quality Improvement

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality Department toll free at (888) 562-5442, or fax (855) 260-8743.

The address for mail requests is:

Molina Healthcare of Idaho, Inc.
Quality Improvement Department
7050 Union Park Center, Suite 200
Midvale, UT 84047

This Provider Manual contains excerpts from the Molina Quality Improvement Program (QIP). For a complete copy, please contact your Provider Services Representative or call the telephone number above to receive a written copy.

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

Molina does not delegate Quality Improvement activities to Medical Groups/IPAs. However, Molina requires contracted Medical Groups/IPAs and other delegated entities 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's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential Quality of Care and/or Critical Incident investigations; and,
- Allow access to Molina Quality personnel for site and medical record review processes.

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina 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 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) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General report to Congress regarding the incidence of "never events" among Medicare beneficiaries, the payment for services in connection with such events, and the Centers for Medicare & Medicaid Services (CMS) processes to identify events and deny payment.

Quality of Care

Molina has an established and systematic process to identify, investigate, review and report any potential Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable), and/or service issues affecting Member care. Molina 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.

Molina is not required to pay for inpatient care related to "never events".

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. PCPs should maintain the following components:

- Medical record confidentiality and release of medical records are maintained including behavioral health care records;
- Medical record content and documentation standards are followed, including preventive health care;
- Storage maintenance and disposal processes are maintained; and
- Process for archiving medical records and implementing improvement activities is outlined.

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 and HIPPA 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 remain consistent in their practices with Molina's medical record documentation guidelines. Medical records are maintained and should include the following information:

- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- Information about services delivered by these Providers.
- A problem list that describes the Member's 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 (or notation that none are known).
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with member, and a copy of Advance Directives when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Practitioner.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate.

- Notes from consultants if applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report;
- Labor and Delivery Record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

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.
- A release document for each Member authorizing Molina to release medical 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 Molina and the External Quality Review Organization upon request.
- The medical record is available to the Member upon their request.
- A storage system for inactive member medical records which allows retrieval within twenty-four (24) hours, is consistent with State and Federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than ten (10) years.
- 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 or 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 and enrollment information.
- Medical Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Molina Quality Department toll free at (888) 562-5442. See also the Compliance section of this Provider Manual regarding 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 Care Providers (PCP) (adult and pediatric) and participating specialists (to include OB/GYN, behavioral health practitioners, and high volume and high impact specialists). Providers are required to conform to the appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on ninety percent (90%) availability for Emergency Services and ninety percent (90%) or greater for all other services. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (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:

Medical Appointment Types	Standard
Routine, Preventative for wellness exams and immunizations	Within (42) calendar days
Routine assessment, for follow up of stable or chronic conditions	Within (30) calendar days
Urgent Care	Within twenty-four (24) hours.
After Hours Care	Twenty-four (24) hours/seven (7) days a week availability.
Specialty Care for routine care	Within twenty (30) calendar days.
Urgent Specialty Care	Within twenty-four (24) hours.

Behavioral Health Appointment Types	Standard
Life Threatening	Immediately
Non-Life Threatening	Within six (6) hours.
Urgent Care	Within twenty-four (24) hours.
Routine Care	Within fourteen (14) calendar days.
Follow-up Routine Care	Within thirty (30) calendar days.

Additional information on appointment access standards is available from your local Molina Quality Department toll free at (888) 562-5442.

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 to 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 telephone 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 Provider Services Department toll free at (888) 562-5442 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-bound 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 obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina 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 www.MolinaHealthcare.com website or is available from your local Molina Quality Department toll free at (888) 562-5442.

Monitoring Access for Compliance with Standards

Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis.

Provider network adherence to access standards is monitored via the following mechanisms:
1. Provider access studies – Provider office assessment of appointment availability, and after-hours access.
2. Member complaint data – Assessment of Member complaints related to access to care.
3. Member satisfaction survey – Evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee. Additional information on access to care is available under the Resources tab on the www.MolinaHealthcare.com website or is available from your local Molina Quality Department toll free at (888) 562-5442.

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/grievances 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 Record Keeping Practices") 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 as identified during the compliant/grievance review process 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 (1) medical/treatment record for the areas described in the "Medical Record Keeping Practices" 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 eighty percent (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 Provider.
- 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 ten (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 injectables 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 (CAP) 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 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 (6) month intervals as needed 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 Providers 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 (3) 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 (eighteen [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.

New adult Members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their Member Handbook, Evidence of Coverage (EOC) and other Member communications such as newsletters and the Molina website. If a Member is incapacitated at the time of enrollment, Molina will provide advance directive information to the Member's family or representative, and will follow up with information to the Member at the appropriate time. All current Members will receive annual notice explaining this information, in addition to newsletter information.

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.

PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

Molina network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may

select a new PCP if the assigned Provider has an objection to the Member's desired decision. Molina Medicare will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an Advance Directive. CMS Law gives Members the right to file a complaint with Molina or the State survey and certification agency if the Member is dissatisfied with Molina's handling of Advance Directives and/or if a Provider fails to comply with Advance Directives instructions.

Molina will notify the Provider via fax of an individual Member's Advance Directives identified through care management, Care Coordination or Care 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 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 section under Healthcare Services in this Provider Manual.

Care Management

Molina's Care Management Programs involve 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 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. For additional information please see the Care Management section under Healthcare Services in 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 appropriate established authority. CPGs are reviewed annually and are updated as new recommendations are published.

Molina CPGs include but are not limited to the following:

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Obesity
  Detoxification and Substance Abuse
- Opioid
- Sickle Cell Disease

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, 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 Quality Department toll free at (888) 562-5442.

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 twenty-four (24) months old.
- Care for children up to two to nineteen (2-19) years old.
- Care for adults twenty to sixty-four (20-64) years old.
- Care for adults sixty-five (65) years old 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 an 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)
- Consumer Assessment of Healthcare Providers and Systems® (CAHPS)
- Health Outcomes Survey (HOS)
- Provider Satisfaction Survey
- 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 Quality Department toll free at (888) 562-5442, or by visiting our website at www.MolinaHealthcare.com.

Healthcare Effectiveness Data and Information Set® (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, diabetes care, well check-ups, medication use and cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina's clinical quality 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.

Consumer Assessment of Healthcare Providers and Systems® (CAHPS)

CAHPS® is the tool used by Molina to summarize Member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care, and Getting Needed Prescription Drugs. The CAHPS® survey is administered annually in the spring to randomly selected Members by an approved NCQA©-certified vendor.

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

Medicare Health Outcomes Survey (HOS)

The HOS measures Medicare Members' physical and mental health status over a two (2) year period and categorizes the two (2) year change scores as better, same, or worse than expected. The goal of the HOS is to gather valid, reliable, clinically

meaningful data that can be used to target quality improvement activities and resources, monitor health plan performance and reward top performing health plans. Additionally, the HOS is used to inform beneficiaries of their health care choices, advance the science of functional health outcomes measurement, and for quality improvement interventions and strategies.

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 used 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.

Medicare Star Ratings – The Affordable Care Act

With the passage of the Affordable Care Act, the health care industry will be subject to greater scrutiny wherever taxpayer dollars are involved. One method of oversight is Medicare "Star Ratings". Star ratings are not new, but in the current regulatory climate, value-based payment will be receiving more focus.

Star Ratings are a system of measurements CMS uses to determine how well physicians and health plans are providing care to Medicare Members. This system is based on nationally-recognized quality goals such as "The Triple Aim" and the Institute of Medicine's "Six Aims," which focus on improving the health and care of your patients, safe and effective care, as well as making care affordable. These aims are realized through specific measures.

Preventive Health:
- Annual wellness/physical exams
- Mammograms
- Osteoporosis Testing and Management
- Influenza and Pneumonia Immunizations

Chronic Care Management:
- Diabetes management screenings
- Cardiovascular and hypertension management screenings
- Medication adherence for chronic conditions
- Rheumatoid arthritis management

Member Satisfaction Survey Questions:
- "…rate your satisfaction with your personal doctor"
- "…rate your satisfaction with getting needed appointments"

What Can Providers Do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology;
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed;
- Check that staff is properly coding all services provided; and,
- Be sure patients understand what *they* need to do.

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please go to www.MolinaHealthcare.com and click on Providers. There is a variety of resources, including:
- HEDIS® CPT/CMS-approved diagnostic and procedural code sheet.
- A current list of HEDIS® and CAHPS® Star Ratings measures.

11. Compliance

Fraud, Waste and Abuse

Introduction

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. Molina 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

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or Law enforcement agency.

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.

Regulatory Requirements

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

The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina who receive or pay out at least five (5) million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina, 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; and,
- Employee protection rights as whistleblowers.

The Federal False Claims Act and state Medicaid False Claims Acts 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 (2) times the amount of back pay plus interest; and,
- 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 payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the Law.

Anti-Kickback Statute – Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or

reward business payable or reimbursable under the Medicare or other Federal health care programs.

Stark Statute – Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to Medicare and Medicaid services provided only by physicians, rather than by all health care Practitioners.

Sarbanes-Oxley Act of 2002 – Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

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 Medicare program.

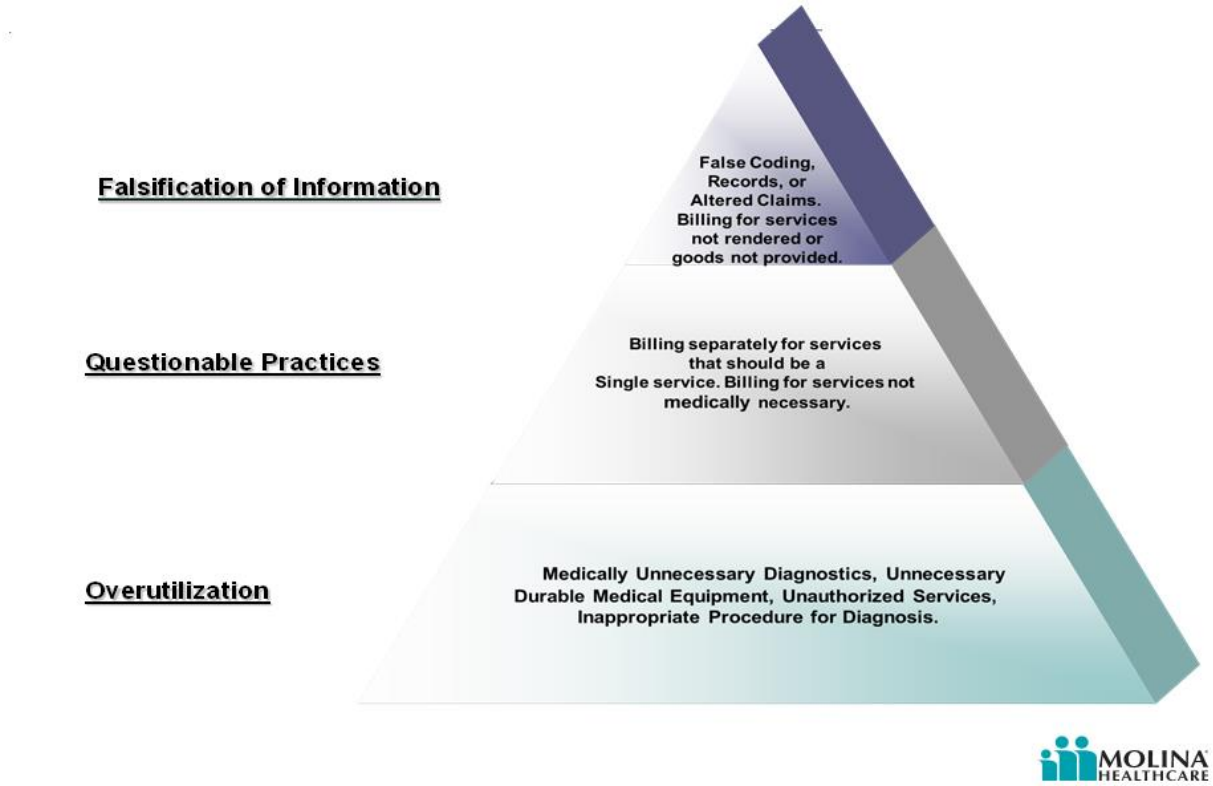
Abuse: Means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicare program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.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

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 Member 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 occurs 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 government funded programs like Medicare or 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 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.

Provider Education

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

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan to Molina addressing the issues identified and how it will cure these issues moving forward.

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 twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (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 (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 to Molina's Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Idaho, Inc.
Attn: Compliance
200 Oceangate, Suite 100
Long Beach, CA 90802

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 at:

Idaho Office of the Attorney General
700 W. Jefferson Street
P.O. Box 83720
Boise, ID 83720-0010
Phone (208) 334-2400
Fax (208) 854-8071
Website: http://www.ag.idaho.gov/medicaidFraud/medicaidFraud_index.html

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 Providers 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.

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law, including:
- 42 C.F.R. Part 2 regulations
- Health Information Technology for Economic and Clinical Health Act (HITECH Act)

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)
   - 42 C.F.R. Part 2
   - 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[1]. 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, such as preauthorization of services, concurrent review, and retrospective review of "services[2]."

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

[1] See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

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.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

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 and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

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

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 who wish to conduct HIPAA standard transactions with Molina 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. Click on the tab titled "HIPAA Transactions" 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

Providers 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.

Reimbursement for Copies of PHI

Molina does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review
- Resolution of an Appeal and Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® medical records

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 Healthcare 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 Healthcare 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 Healthcare in writing, except to the extent that:
    a) action has been taken in reliance on this authorization; or
    b) 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 twelve (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 Healthcare.

12. 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:

- Hospital-Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Medicaid Coverage for Molina Medicare Members
- Timely Claim Filing
- Claim Edit Process
- Claim Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Claim Payment
- Overpayment and Incorrect Payment
- Claims Disputes/Reconsiderations
- Billing the Member
- Fraud and Abuse
- Encounter Data

For Medicaid specific coverage and compensation information, please reference the Idaho Medicaid manual located on the Provider Website.

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

Participating Providers are required to submit Claims to Molina 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 Portal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: UT – SX109 and 12X09 or ID – 61799. 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.

Claims that do not comply with Molina's electronic Claim submission requirements will be denied, except in the State of Idaho.

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 with the exception of Idaho, as Participating Providers are allowed to submit paper claims.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed thirty (30) calendar days from the change.

Electronic Claims Submission

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 via the at Provider Portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 61799.

Provider Portal

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

- Available to all Providers at no cost.
- Available twenty-four (24) hours per day, seven (7) days per week.
- Ability to add attachments to claims (Portal and clearinghouse submissions).
- Ability to submit corrected claims.
- Easily and quickly void claims.
- Check claims status.
- Receive timely notification of a change in status for a particular claim.

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 this 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 will still be accepted in the State of Idaho.

Molina Healthcare of Idaho, Inc.
PO BOX 22617
Long Beach, CA 90801

Coordination of Benefits (COB) and Third Party Liability (TPL)

For Members enrolled in a Molina plan, Molina and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these Members. Molina will pay claims for covered services; however if TPL/COB is determined Molina may cost avoid if appropriate or request recovery post payment. Molina will attempt to recover any overpayments paid as the primary payer when another insurance is primary.

Medicaid Coverage for Molina Medicare Members

There are certain benefits that will not be covered by Molina Medicare program but may be covered by **fee-for-service Medicaid**. In this case, the Provider should bill Medicaid with a copy of the Molina Medicare remittance advice and the associated state agency will process the claim accordingly.
After exhausting all other primary coverage benefits, Providers may submit claims to Molina Medicare. A copy of the remittance advice from the primary payer must accompany the claim or the claim will be denied. If the primary insurance paid more than Molina's contracted allowable rate the claim is considered paid in full and zero dollars will be applied to claim.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form 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 and procedures. Claims must be submitted by Provider to Molina within three-hundred-sixty-five (365) days after the 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 three-hundred-sixty-five (365) 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 State and 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).
  - CMS 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 Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

Coding Sources

Definitions

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 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*F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number – ICN/DCN).

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).

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 schedule, Molina will process the claim for service within thirty (30) days after receipt of Clean Claims. The receipt date of a Claim is the date Molina receives notice of the Claim.

Electronic Claim Payment

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. Additional

information about EFT/ERA is available at www.MolinaHealthcare.com or by contacting our Provider Services Department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, 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.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider.

If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the Overpayment.

Provider Claim Redeterminations – Contracted Providers

Providers disputing a Claim previously adjudicated must request such action, in writing or via the Provider Portal, utilizing Molina's Provider Research and Resolution process within one-hundred-twenty (120) days of Molina's original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following:

- Requests must be fully explained as to the reason for redetermination.
- Previous claim and remittance advice, any other documentation to support the request and a copy of the referral/authorization form (if applicable) must accompany the request.
- Requests for claim redetermination should be sent via Fax to: **(877) 682-2218; Attn: Appeals**

Note: Corrected claims are to be directed through the original claims submission process, clearly identified as a corrected claim.

All questions pertaining to claim redetermination requests are to be directed to the Member & Provider Contact Center toll free at **(844) 239-4913**, seven (7) days a week, from 8:00 a.m. to 8:00 p.m., local time. TTY/TDD users, please call 711.

Provider Reconsideration of Delegated Claims – Contracted Providers

Providers requesting a reconsideration, correction or reprocessing of a claim previously adjudicated by an entity that is delegated for claims payment must submit their request to the delegated entity responsible for payment of the original claim.

Billing the Member

- Providers contracted with Molina 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.
- Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
  - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
  - The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.
  - The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

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 one-hundred-twenty (120) days from the date of service 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.

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

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.

13. Member Grievances and Appeals

Molina Members have the right to file and submit a grievance and/or appeal through a formal process. Members may elect a personal representative or a Provider to file the grievance or appeal on their behalf.

Complaints, Grievances and Appeals Process

1. **Complaints –** may be either grievances or appeals or both and may be processed under one or both procedures. The Appeals and Grievance Form can be completed by the Member or representative when filing and submitting a grievance or appeal.

   Each issue is adjudicated separately. **Complaints or disputes involving organization determinations are processed as appeals.** All other issues are processed as grievances. General guidelines that are used to determine the category of the complaint are:
   - The grievance process will be used for complaints concerning disenrollment, cost sharing, changes in premiums, and access to a Provider or Molina;
   - Changes in Provider availability to a specific Member will be considered an organization determination.
   - The QIO process is used for complaints regarding quality of medical care.

2. **Grievances** – Grievance procedures are as follows:
   - Molina will accept any information or evidence concerning the grievance orally or in writing not later than sixty (60) days after the event and will thoroughly investigate, track and process the grievance within thirty (30) days unless an extension is granted;
   - If Molina extends the time necessary or refuses to grant an organization determination or reconsideration Molina will respond to the Member within twenty-four (24) hours; and,
   - Complaints concerning the timely receipt of services already provided are considered grievances.

   Quality of Care – Molina Members have a right file a complaint regarding the care provided. Molina must respond to all Quality of Care complaints in writing to the Member. Molina monitors, manages, and improves the quality of clinical care and services received by its Members by investigating all issues including Serious Adverse Events, Hospital Acquired Conditions and Never Events. Members may also file care complaints with the State's contracted and CMS assigned Quality Improvement Organization.

3. **Organization Determination**

Organization Determinations are any determinations (an approval, modification or denial) made by Molina regarding payment or services to which a Member believes he/she is entitled such as temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.

Molina Utilization Management Department handles organization determination. Organization Determination is discussed in the Healthcare Services section of this Provider Manual. Any party to an organizational determination, e.g., a Member, a Member's representative or a non-contracted Provider, or a termination of services decision, may request that the determination be reconsidered.

Organization determinations are either standard or expedited depending on the urgency of the Member's request.

4. **Part-D Appeals – Please see the Medicare Part D section in this Provider Manual.**

Definition of Key Terms used in the Molina Medicare Grievance and Appeal Process

The definitions that follow will clarify terms used by Molina for Member appeals and grievances. Following the definitions is a brief discussion of Molina grievance and appeal processes. Any questions on these polices should be directed to your Provider Services Representative.

Appeal	Any of the procedures that deal with the review of adverse organization determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by Molina Medicare and if necessary, an independent review entity, hearing before an Administrative Law Judge (ALJ), review by the Medicare Appeals Council (MAC), and judicial review.
Assignee	A non-contracted Provider who has furnished a service to the Member and formally agrees to waive any right to payment from the Member for that service.
Complaint	Any expression of dissatisfaction to Molina, Provider, facility or Quality Improvement Organization (QIO) by a Member made orally or in writing. This can include concerns about the operations of Providers or Molina such as: waiting times, the demeanor of health

	care personnel, the adequacy of facilities, respectfulness shown Members, the right of the Member to receive services or payment for services previously rendered. It also includes a plan's refusal to provide services to which the Member believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.
Coverage Determination: Denial Notices	A written denial notice by Molina that states the specific reasons for the denial and informs the Member of his or her right to reconsideration. The notice describes both the standard and expedited appeals processes and the rest of the appeals process. For payment denials, the notice describes the standard redetermination process and the rest of the appeals process.
Effectuation	Compliance with a reversal of Molina original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.
Member	A Medicare-eligible individual who has elected a Medicare plan offered by a Medicare Advantage organization, or a Medicare eligible individual who has elected a cost plan or HCPP.
Independent Review Entity	An independent entity contracted by CMS to review Molina's adverse reconsiderations of organization determinations.
Inquiry	Any oral or written request to Molina, Provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by a Member.
Medicare Plan	A plan defined in 42 CFR. 422.2 and described in 422.4.
Organization Determination	Any determination made by Molina with respect to any of the following: • Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; • Payment for any other health services furnished by a Provider other than a Molina Medicare Provider that the Member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Molina; • Molina's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by the Medicare health plan; • Discontinuation of a service if the Member believes that continuation of the services is medically necessary; and/or, • Failure of Molina to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse

	determination, such that a delay would adversely affect the health of the Member.
Quality Improvement Organization (QIO)	Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare Members. QIOs review complaints raised by Members about the quality of care provided by Providers, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Molina, and ambulatory surgical centers. The QIOs also review continued stay denials for Members receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.
Quality of Care Issue	A quality of care complaint may be filed through the Molina grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by Molina meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.
Reconsideration	A Member's first step in the appeal process after an adverse organization determination; Molina or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.
Representative	An individual appointed by a Member or other party, or authorized under State or other applicable law, to act on behalf of a Member or other party involved in the appeal. Unless otherwise stated, the representative will have all of the rights and responsibilities of a Member or party in obtaining an organization determination or in dealing with any of the levels of the appeals process, subject to the applicable rules described in 42 CFR part 405.

Important Information about Member Appeal Rights

For information about Members' appeal rights, call Molina's Medicare Member & Provider Contact Center toll free at (844) 239-4913, or 711 for persons with hearing impairments (TTY/TDD).

Below is information for Molina Members regarding their appeal rights. A detailed explanation of the appeal process is included in the Member's Evidence of Coverage (EOC) that has been provided to them. If Members have additional questions, please refer them to Molina's Member & Provider Contact Center.

There Are Two (2) Kinds of Appeals You Can File: **Standard Appeal Thirty (30) days** – You can ask for a standard appeal. Your plan must give you a decision no later than thirty (30) days after it gets your appeal. Your plan may extend this time by up to fourteen (14) days if you request an extension, or if it needs additional information and the extension benefits you. **Fast Seventy-two (72) hour review** – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide on a fast appeal no later than seventy-two (72) hours after it gets your appeal. Your plan may extend this time by up to fourteen (14) days if you request an extension, or if it needs additional information and the extension benefits you. If any Provider asks for a fast appeal for you, or supports you in asking for one, and the Provider indicates that waiting for thirty (30) days could seriously harm your health, your plan will automatically give you a fast appeal. If you ask for a fast appeal without support from your Provider, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal in thirty (30) days	**What do I include with my Appeal?** You should include your name, address, Member ID number, reason for appealing and any evidence you wish to attach. You may send in supporting medical records, Provider's letter(s), or other information that explains why your plan should provide service. Call your Provider if you need this information to help with your appeals. **How do I file an Appeal?** For Standard Appeal: you or your authorized representative should mail or deliver your written appeal to Molina Medicare at: Molina Healthcare Medicare Attn: Grievance and Appeals P.O. Box 22816 Long Beach, CA 90801-9977 **Hours of Operation:** Monday through Sunday 8:00 a.m. to 8:00 p.m. **To file an oral grievance call us toll free:** (844) 239-4913 **TTY/TDD toll free access number:** 711 **Fax Number:** (844) 251-1450 **Other resources: Medicare Rights Center:** Toll free: (888) HMO-9050 Toll free: (800) MEDICARE - (800) 633-4227 If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights toll free at (800) 368-1019 or TTY/TDD (800) 537-7697, or call your local Office for Civil Rights.

14. Credentialing and Recredentialing

The purpose of the Credentialing Program is to assure the Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification 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

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. 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.

Telemedicine – the practice of medicine using electronic communications, information technology, or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional encounter in person between a practitioner and a patient.

Type of Practitioners Credentialed & Recredentialed

Practitioners and groups of practitioners with whom Molina contracts must be credentialed prior to the contract being implemented. These practitioners must be licensed, certified or registered by the state to practice independently.

Providers that are licensed as organizations or facilities will be credentialed as an Organizational Provider (please refer to the policy titled Assessment of Organizational Providers).

<u>Practitioner types requiring credentialing include but are not limited to:</u>

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral healthcare practitioners who are licensed, certified or registered by the state to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Medical Doctors (MD)

- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons.
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Psychologist
- Speech and Language Pathologists
- Telemedicine Practitioners

Criteria for Participation in the Molina 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 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 Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined 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 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 network. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

- **Application** – Provider must submit to Molina a complete credentialing application and signed attestation within 180 days. Application must include all required attachments.
- **License, Certification or Registration** – Provider must hold an active, valid and unrestricted 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.

- **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.
- **Education and Training** – Providers will only be credentialed in an area of practice in which they have adequate education. Provider must have graduated from an accredited school with a degree in their designated specialty.
    - **Residency Training** – Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing.
    - **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.
- **Board Certification** – Board certification in the specialty in which the Provider is practicing is preferred but not required. Verification of board certification is primary source verified directly with the American Board of Medical Specialties.
- **Work History** – Provider must supply most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional.
- **Malpractice History** – Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance** – Provider must supply current professional malpractice liability insurance coverage on application or current copy of certificate. Provider must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the provider's activities on Molina's behalf.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).
- **SSA Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.

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 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 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 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 Professional Review Committee's review must be re-verified. The Professional Review 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 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 is a break in the contract period of more than thirty (30) calendar days, Molina must credential the Provider as a new provider before the Provider rejoins the network.

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. 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.

Non-Discriminatory Credentialing and Recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, 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 Professional Review 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.

Providers Rights during the Credentialing Process

Providers have the right to review their credentials file at any time. Provider's rights are published in the online Provider Manual for them to review at any time. A copy of the Provider Manual is also sent to the Provider at the time of initial contracting.

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 Provider 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, 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 administratively 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.

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.

Excluded 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 the following agencies for Provider sanctions and exclusions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality is identified. If a Molina Provider is found to be sanctioned or excluded, the Provider's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).

- **Medicare Exclusion Database (MED)** – Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **National Practitioner Database** – Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Providers sanctioned with SAM.

Molina also monitors the following for all Provider types between the recredentialing cycles.

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

15. Delegation

This section contains information specific to Molina's delegation criteria. Molina may delegate certain administrative responsibilities upon meeting all of Molina's delegation criteria. Molina is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted entities. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

Delegation Criteria

Sanction Monitoring

All sub-contractors of Molina are required to show proof of processes to screen staff and employees at all levels against Federal exclusions lists. Screening must done prior to the employee/staff's hire date, and occur monthly thereafter. Molina will include a Sanction Monitoring pre-assessment audit with all other pre-assessment audits, any time a function(s) is/are being considered for delegation.

Sanction monitoring functions may be delegated to entities which meet Molina criteria. To be delegated for sanction monitoring functions, Providers must:

- Pass Molina's sanction monitoring pre assessment, which is based on CMS standards.
- Demonstrate that employees and staff are screened against Office of Inspector General (OIG) and System for Award Management (SAM) sanction lists prior to hire dates, and monthly thereafter.
- 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 sanction monitoring delegates.
- Submit timely and complete Sanction Monitoring delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.
- When staff or employees are identified as having a positive sanction, provide Molina with notification according to Contractual Agreements of the findings and action(s) being taken to ensure sanctioned staff is not providing services to Molina Members.

Credentialing

Credentialing functions may be delegated to entities which meet National Committee for Quality Assurance© (NCQA) criteria for credentialing functions. To be delegated for credentialing functions, Providers must:

- Pass Molina's credentialing pre-assessment, 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 and SAM exclusion lists 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 Provider is an NCQA© Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modification 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.

If the Provider 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.

An entity may request Credentialing delegation from Molina through Molina's Delegation Oversight Manager or through their 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 entity's ability to meet Molina, State and Federal requirements for delegation.

Delegation Reporting Requirements

Delegated entities contracted with Molina 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 Contract Manager.

16. Medicare Part D

A Part D coverage determination is a decision about whether to provide or pay for a Part D drug, a decision concerning a tiering exception request, a formulary exception request, a decision on the amount of cost sharing for a drug, or whether a Member has or has not satisfied a prior authorization or other UM requirement.

Any party to a coverage determination, (e.g., a Member, a Member's representative, or a Member's prescriber) may request that the determination be appealed. A Member, a Member's representative, or Provider, are the only parties who may request that Molina expedite a coverage determination or redetermination.

Coverage determinations are either standard or expedited depending on the urgency of the Member's request.

Appeals/Redeterminations

When a Member's request for a coverage determination is denied, Members may choose someone (including an attorney, Provider, or other authorized representative) to serve as their personal representative to act on their behalf. After the date of the denial, a Member has up to sixty (60) days to request a redetermination. This is the first level of appeal for Part D adverse decisions. Appeal data is confidential.

The redetermination request will be responded to within seven (7) days. If an expedited appeal is required for an emergent situation, then the decision will be made within seventy-two (72) hours of the request.

At any time during the appeal process, the Member or personal representative may submit written comments, papers or other data about the appeal in person or in writing. If the appeal/reconsideration is denied, the Member has the right to send the appeal to the Independent Review Entity (IRE) within sixty (60) days of receipt of the appeal. The IRE has seven (7) days to make a decision for a standard appeal/reconsideration and seventy-two (72) hours for an expedited request. The IRE will notify Molina and the Member of the decision. When an expedited review is requested, the IRE will make a decision within seventy-two (72) hours.

If the IRE changes the Molina decision, authorization for service must be made within seventy-two (72) hours for standard appeals and within twenty-four (24) hours for expedited appeals.

Payment appeals must be paid within thirty (30) days from the date the plan receives notice of the reversal.

If the IRE upholds Molina's denial they will inform the Member of their right to a hearing with the ALJ and will describe the procedures that must be followed to obtain an ALJ hearing.

CMS's IRE monitors Molina's compliance with determinations to decisions that fully or partially reverse an original Molina denial. The IRE is currently Maximums Federal Services, Inc.

Part D Prescription Drug Exception Policy

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits a Member is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, a Member can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost UM tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

Molina is committed to providing access to medically necessary prescription drugs to Members of Molina. If a drug is prescribed that is not on Molina's formulary, the Member or Member's representative may file for an exception. All exceptions and appeals are handled at the plan level (on-site) and are not delegated to another entity. Please see below for contact information by plan for personnel who handle the exceptions. Members or the Member's representatives (who can include Providers and pharmacists) may call, write, fax, or e-mail Molina's exception contact person to request an exception. Procedures and forms to apply for an exception may be obtained from the contact persons.

Part D Exceptions and Appeals Contact Information: call Molina toll free at (844) 239-4913 or fax (844) 251-1450.

The Policy and Procedure for Exceptions and Appeals will be reviewed by a Pharmacy and Therapeutics (P&T) Committee on an annual basis at minimum. Exception/Prior Authorization criteria are also reviewed and approved by a P&T Committee.

1. **Formulary** – A formulary is a list of medications selected by Molina in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Molina will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Molina network pharmacy, the prescription is being used for a medically accepted indication (i.e., either FDA approved or compendia supported for the diagnosis for which it is being used), and other plan rules are followed.

Formularies may be different depending on the Molina plan and will change over time. Current formularies for all products may be downloaded from our website at www.MolinaHealthcare.com.

2. **Copayments for Part D** – The amount a patient pays depends on which drug tier the drug is in under the plan and whether the patient fills the prescription at a preferred network pharmacy.
   - Most Part D services have a co-payment;
   - Co-payments cannot be waived by Molina Medicare per CMS; and
   - Co-payments for Molina Medicare may differ by state and plan.

3. **Restrictions on Molina's Medicare Drug Coverage**

   Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:
   - **Prior Authorization:** Molina requires prior authorization for certain drugs, some of which are on the formulary and also drugs that are not on the formulary. Without prior approval, Molina may not cover the drug;
   - **Quantity Limits:** For certain drugs, Molina limits the amount of the drug that it will cover;
   - **Step Therapy:** In some cases, Molina requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, Molina may not cover drug B unless drug A is tried first; and/or
   - **Part B Medications:** Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration. Newly FDA approved drugs are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee.

4. **Non-Covered Molina Healthcare Medicare Part D Drugs:**
   - Agents when used for anorexia, weight loss, or weight gain (no mention of medically necessary);
   - Agents when used to promote fertility;
   - Agents used for cosmetic purposes or hair growth;
   - Agents used for symptomatic relief of cough or colds;
   - Prescription vitamins and minerals, except those used for prenatal care and fluoride preparations;

- Non-prescription drugs, except those medications listed as part of Molina's Medicare over-the-counter (OTC) monthly benefit as applicable and depending on the plan;
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale;
- Molina Members with Medicaid coverage may have a limited selection of these excluded medications as part of its Medicaid coverage for Members assigned to Molina Medicaid.
- Prescriptions that are not being used for a medically accepted indication (i.e., prescriptions must either be FDA-approved or compendia supported for the diagnosis for which they are being used; the Medicare-approved compendia are American Hospital Formulary Service Drug Information (AHFS) and DRUGDEX® Information System).

5. **There may be differences between the Medicare and Medicaid Formularies.** The Molina Formulary includes many injectable drugs not typically found in its Medicaid formularies such as those for the aged, blind and disabled.

6. **Requesting a Molina Medicare Formulary Exception –** Molina Medicare product drug prior authorizations are called Exceptions, which are required when your patient needs a drug that is not on the Formulary. A Member, a Member's appointed representative or a Member's prescribing Provider are permitted to file an Exception. (The process for filing an exception is predominantly a fax based system.) The form for exception requests is available on the Molina website.

7. **Requesting a Molina Medicare Formulary Redetermination (Appeal) –**The appeal process involves an adverse determination regarding Molina Medicare issuing a denial for a requested drug or claim payment. If the Member received a Notice of Denial of Medicare Prescription Drug Coverage and disagrees with the decision rendered, he/she may request a redetermination (appeal) from Molina Medicare by completing the appeal form sent with the Notice of Denial.

   A Member, a Member's appointed representative or a Member's prescribing Provider (for expedited appeals) may complete the appeal form and submit any information which may help Molina with the processing of the appeal. An appeal must be submitted in writing and filed within sixty (60) calendar days from the date that the determination was rendered.

   - A standard appeal may be submitted to Molina in writing or can be taken over the telephone. The appeal will be reviewed upon receipt and the Member will be notified in writing within seven (7) calendar days from the date the request for re-determination is received.

- An expedited appeal can be requested orally or in writing by the Member or by a Provider acting on behalf of the Member. An expedited appeal may be requested in situations where applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum function. If a Provider supports the request for an expedited appeal, Molina will honor this request.
- If a Member submits an appeal without Provider support, Molina will review the request to determine if it meets Medicare's criteria for expedited processing. If the plan determines that the request meets the expedited criteria, Molina will render a decision as expeditiously as the Member's health requires, but not exceeding seventy-two (72) hours. If the request does not meet the expedited criteria, Molina will render a coverage decision within the standard redetermination time frame of seven (7) calendar days.
- To submit a verbal request, please call toll free (844) 239-4913. Written appeals must be mailed or faxed toll free (866) 290-1309.

8. **Initiating a Part D Coverage Determination Request –** Molina will accept requests from Providers or a Member's appointed representative on the behalf of the Member either by a written or verbal request. The request may be communicated through the standardized Molina Medication Prior Authorization Request Form or through telephone via fax and telephone lines. All requests will be determined and communicated to the Member and the Member's prescribing Provider with an approval or denial decision within seventy-two (72) hours/three (3) calendar days after Molina receives the completed request.

   Molina will request submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by: 1) Molina Pharmacy Technician under the supervision of a pharmacist; 2) Molina Pharmacist; or, 3) Chief Medical Officer (CMO) of Molina. Review criteria will be made available at the request of the Member or his/her prescribing Provider. Molina will determine whether a specific off-label use is a medically accepted indication based on the following criteria:

   a. A prescription drug is a Part D drug only if it is for a medically accepted indication, which is supported by one or more citations included or approved for inclusion with the following compendia:
      - American Hospital Formulary Service Drug Information; and
      - DRUGDEX Information System.

   b. Requests for off-label use of medications will need to be accompanied with excerpts from one (1) of the two (2) CMS-required compendia for consideration. The submitted excerpts must site a favorable recommendation.

c. Depending upon the prescribed medication, Molina may request the prescribing Provider to document and justify off-label use in clinical records and provide information such as diagnostic reports, chart notes, and medical summaries.

Denial decisions are only given to the Member or Member's representative by a Pharmacist or CMO of Molina. The written denial notice to the Member (and the prescriber involved) includes the specific rationale for denial; the explanation of both the standard and expedited appeals process; and an explanation of a Member's right to, and conditions for, obtaining an expedited an appeals process.

If Molina denies coverage of the prescribed medication, Molina will give the Member a written notice within seventy-two (72) hours explaining the reason for the denial and how to initiate the appeals process. If no written notice is given to the Member within the specified timeframe, Molina will start the next level of appeal by sending the Coverage Determination request to the IRE within twenty-four (24) hours.

If a coverage determination is expedited, Molina will notify the Member of the coverage determination decision within the twenty-four (24) hour timeframe by telephone and mail the Member a written Expedited Coverage Determination within three (3) calendar days of the oral notification. If Molina does not give the Member a written notification within the specified timeframe, Molina will start the next level of appeal by sending the Coverage Determination request to IRE within twenty-four (24) hours.

9. **Initiating a Part D Appeal –** If Molina's initial coverage determination is unfavorable, a Member may request a first level of appeal, or re-determination within sixty (60) calendar days from the date of the notice of the coverage determination. In a Standard Appeal Molina has up to seven (7) days to make the re-determination, whether favorable or adverse, and notify the Member in writing within seven (7) calendar days from the date the request for re-determination is received. Members or a Member's prescribing Provider may request Molina to expedite a redetermination if the standard appeal timeframe of seven (7) days may seriously jeopardize the Member's life, health, or ability to regain maximum function. Molina has up to seventy-two (72) hours to make the re-determination, whether favorable or adverse, and notify the Member in writing within seventy-two (72) hours after receiving the request for re-determination. If additional information is needed for Molina to make a re-determination, Molina will request the necessary information within twenty-four (24) hours of the initial request for an expedited re-determination. Molina will inform the Member and prescribing Provider of the conditions for submitting the evidence since the timeframe is limited on expedited cases.

10. **The Part D Independent Review Entity (IRE) –** If the re-determination is unfavorable, a Member may request reconsideration by the IRE. The Part D Qualified Independent Contractor is currently MAXIMUS Federal, a CMS contractor that provides second level appeals.
    - **Standard Appeal:** The IRE has up to seven (7) days to make the decision.
    - **Expedited Appeal:** The IRE has up to seventy-two (72) hours for to make the decision.
    - **Administrative Law Judge (ALJ):** If the IRE's reconsideration is unfavorable, a Member may request a hearing with an ALJ if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable on this level of appeal.
    - **Medicare Appeals Council (MAC):** If the ALJ's finding is unfavorable, the Member may appeal to the MAC, an entity within the Department of Health and Human Services that reviews ALJ's decisions. Note: Regulatory timeframe is not applicable on this level of appeal.
    - **Federal District Court (FDC) –** If the MAC's decision is unfavorable, the Member may appeal to a Federal district court, if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable on this level of appeal.

17. Risk Adjustment Management Program

What is Risk Adjustment?

Risk Adjustment is a process that helps to accurately measure the health status of a plan's membership based on medical conditions and demographic information (age, gender, etc.)

Why is Risk Adjustment Important?

- Allows Molina to focus on quality and efficiency.
- Enables us to recognize and address current and potential health conditions early.
- Identifies Members for Case Management referral.
- Ensures accurate payment for the acuity levels of our Members.
- Most importantly, Risk Adjustment allows Molina to have the resources to deliver the highest quality of care to our Members.

Your Role as a Provider

As a provider your documentation is critical to Risk Adjustment because medical records:

- Are a valuable source of diagnosis data.
- Help determine the ICD-10 codes that should be used.
- Ensure that diagnosis data submitted to State and Federal agencies 5is accurate.

For a complete and accurate medical record, all provider documentation must:

- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only submit codes for which the Provider is certain the Member has.
- Contain a treatment plan.
- Be clear and concise.
- Contain the Member's name and date of service.
- Contain the physician's signature and credentials.

RADV Audits

As part of the regulatory process, CMS conducts Risk Adjustment Data Validation (RADV) audits to ensure that diagnosis data submitted by Molina was accurate. All claims/encounters submitted to Molina are subject to federal and internal health plan auditing. If Molina is selected for a RADV audit, Providers will be required to provide medical records to validate the data previously submitted.

Contact Information

For further questions about Molina's Risk Adjustment programs, please contact our team at: mhnwra@MolinaHealthcare.com

18. Idaho Managed Long Term Services and Support (MLTSS)

MLTSS Overview

MLTSS includes both Long-Term Care (LTC) and Home and Community Based Services (HCBS). Long-Term Care is for an individual living in a facility-based care setting (such as a nursing home or intermediate care facility). Home and community-based services provide supportive services in the community so that individuals can continue to live in their home and empower them to take an active role in their health care. These programs serve individuals who are older adults, people with intellectual and/or developmental disabilities, or people with disabilities.

Molina understands the importance of working with our providers and Community Based Organizations (CBO's) in your area to ensure our Members receive long-term services and supports that maintain their independence and ability to be served in the most appropriate setting of their choice, whether in their home or in a nursing facility.

Molina's MLTSS provider network is a critical component to ensuring our Members receive the right care, in the right place, at the right time. The following information has been included to help support our MLTSS provider network and achieve a successful partnership in serving those in need.

MLTSS Services and Molina

Molina offers long-term services and supports to Members, including benefits of the Aged and Disabled Waiver (A&D Waiver) as well as enhanced benefits. MLTSS are designed to assist elderly and physically disabled Members maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective and most appropriate setting. Services for eligible Members are provided in the Member's home, in a certified family home, or in a residential or assisted living facility.

The Aged and Disabled waiver provides eligible individuals the ability to choose and receive the care they need in the home or community rather than in an institution.

MLTSS Benefits and Approved Services

Aged and Disabled Waiver (A&D Waiver)

Benefit	Description
Attendant Care Services	Provides services that involve personal and medically oriented tasks dealing with the functional needs of the Member, including the Member's needs for long-term maintenance, supportive care, or activities of daily living

Benefit	Description
	(ADL). These services can be done by unlicensed persons or delegated to an unlicensed person by a licensed health care professional or the participant.
Homemaker Services	Provides routine housekeeping duties for the Member if there is no one else in the household capable of performing or assisting him with, or both, the following tasks: laundry, essential errands, and meal preparation
Home Deliver Meals	Provides meals delivered to the Member's home to promote adequate participant nutrition.
Companion Services	Provides in-home services to ensure the safety and wellbeing of a Member who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergencies, or other conditions that would require a person on-site. Services include non-medical care, supervision, and socialization provided to a functionally impaired adult.
Environmental Accessibility Adaptations	Provides minor housing adaptations that are necessary to allow the Member to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety.
Personal Emergency Response System (PERS)	PERS is an electronic device that enables a Member to call for help in an emergency. The member may also wear a portable “help” button to allow for mobility. The system is connected to the Member’s phone and programmed to signal a response center once a “help” button is activated.
Day Habilitation	Provides assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the Member resides. Day habilitation services will focus on enabling the Member to attain or maintain his or her maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.
Residential Habilitation	Consist of services and supports that are designed to assist the Member to reside in their own homes, with their families, or in certified family homes. The services and supports that may be furnished include the following:

Benefit	Description
	• Self-direction • Money management • Daily living skills • Socialization • Mobility • Behavior shaping • Personal assistance services
Chore Services	Chore services include the services necessary to maintain the functional use of the home, or to provide a clean, sanitary and safe environment.
Adult Residential Care	Provides a range of services in a homelike, non-institutional setting that include residential care or assisted living facilities and certified family homes.
Adult Day Health	Provides long-term maintenance or supportive services to waiver Members, these services are offered in a non-institutional, community based setting. ADHC provides a variety of health, therapeutic, and social services designed to meet the specialized needs of waiver individuals.
Respite	Provides short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or Member is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature.
Supported Employment	Provides work in integrated work settings for Member with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability.
Specialized Medical Equipment and Supplies	Provides devices, controls, or appliances that enable a Member to increase his abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which he lives.
Skilled Nursing	Services include intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. These services must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho.
Non-medical Transportation	Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources.

Benefit	Description
Consultation	Services are provided by a Personal Assistance Agency to a Member or the Member's family to increase their skills as an employer or manager of their own care.
Dental Services	Medically necessary dental benefits are provided through the Idaho Smiles program. The State's Medicaid dental contract for the Idaho Smiles program includes the complete list of all dental services available to A&D waiver Members.

Enhanced Plan

Benefit	Description
Developmental Disabilities Targeted Service Coordination (TSC) Services	TSC services are for adults age twenty-one (21) and older, who are diagnosed with a developmental disability, and who require and choose assistance to access services and supports necessary to maintain independence in the community.
Personal Care Services (PCS)	Offers services related to a Member's physical or functional requirements and are provided in the Member's home but do not include housekeeping or skilled nursing care.
Intermediate Care Facility	Provide habilitative services and maintains optimal health status for individuals with intellectually disabilities or persons with related conditions.
Nursing Facility	Provide services for Members who because of their mental or physical condition require health-related care and services above the level of room, board, and supervision.

Getting Care, Getting Started

The State of Idaho Department of Health and Welfare (IDHW) is responsible for performing and determining all nursing facility Level of Care Assessments which are required as part of the Medicaid eligibility process and determine if a Member qualifies for waiver services. Molina Healthcare of Idaho, Inc. will have access to IDHW NF LOC and will use IDHW assessments for each Member's plan of care. Molina will manage changes to the Level of Care Assessment that are required as a result of deterioration or improvement in the Member's condition.

Molina's care coordinator is the single point of contact with the Member and will engage with Members and routinely assess for barriers and opportunities to coordinate medical, behavioral health, and LTSS services in a person-centered manner. Specifically, along with developing the fully integrated Individualized Care Plan (ICP) with the Member, the

care coordinator will provide verbal, written and/or alternate format information to the Member regarding:

- After-hours assistance for urgent situations.
- Access to timely appointments.
- Accommodations available to meet individual linguistic, literacy, and preferred modes of communication.
- Advocacy, engagement of family members and informal supports.

At a minimum, the care coordinator name and contact information and hours of availability are included in the care plan, which is shared with all Interdisciplinary Care Team (ICT) participants based on a Member's recorded preferences. All care coordinators are required to keep email and voicemail current with availability or backup as necessary for Members and their Providers.

Molina will ensure the provision of the following service coordination services for the Member:

- Monitor the provision of Covered Services, including outcomes.
- Ensure appropriate referrals and timely two-way transmission of Member information,
- Support safe transitions for Members moving between care settings.
- Coordinate services with the services the Member receives outside of the MMCP. Coordinate services with the services the Member receives in the Developmental Disability (DD) Waiver and services authorized under section 1915(i) State Plan Amendment Option.
- Coordinate services with the services the Member receives from community and social support providers; and,
- Coordinate transitions for Member that transition from or to another Health Plan. This includes timely sharing of information necessary to ensure a smooth transition of services for the Member.

Molina is responsible for documentation related to Members' eligibility for A&D Waiver or PCS services, as a result of the Level of Care assessment. Documentation includes, but is not limited to:

- Service and Provider Choice Form
- Significant Change Form
- Notice of Change Form
- Agency Change Form
- Fiscal Intermediary Memorandum of Understanding, if applicable

Molina will work closely with the various Community Based Organizations (CBO's) to address other needs of Members in the MMCP program.

Once you have been identified as the provider of service, it will be your responsibility for billing of these services. The Individualized Care Plan (ICP) will document services, duration and any other applicable information.

Interdisciplinary Care Team (ICT)

All MLTSS Members will receive service coordination and/or care management and be assigned a Care Coordinator from the Molina Plan.

The person centered Interdisciplinary Care Team (ICT) for MLTSS will include, at a minimum, the Member and/or their authorized representative, Care Coordinator and PCP. For Members accessing 1915(c) Traditional DD or 1915(i) services, their DD Plan Developer/Plan Monitor/Targeted Service Coordinator is a required member of the ICT. ICT members may also include LTSS providers (e.g. Adult Day Health Care Center staff, Personal Care, Homemaker, Nursing Facility staff, *etc.*), specialist(s), behavioral health clinician, Targeted Case Management service providers, and pharmacist. The ICT can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required members.

Individualized Care Plan Coordination (ICP)

LTSS services to be covered by Molina will require coordination and approval.

ICP includes the consideration of medical, behavioral, and long-term care needs of the Member identified through a person-centered assessment process. The ICP includes informal care, such as family and community supports. A Person Centered Service Plan is a part of the ICP and documents the amount, duration, and scope of the home and community based services. The service plan is person centered and must reflect the services and supports that are important for the Member to meet their needs, goals and preferences that are identified through an assessment of functional need. The service plan will also identify what is important with regard to the delivery of these services and supports (42 CFR 441.301).

The Individualized Care Plan (ICP) will be developed under the Member's direction and implemented by assigned members of the Interdisciplinary Care Team (ICT) no later than one-hundred-twenty (120) calendar days from the time of enrollment or within thirty (30) calendar days of the completion of the Comprehensive Health Risk Assessment, whichever occurs first. All services and changes to services must be documented in the ICP and be under the direction of the Member in conjunction with the care coordinator.

The Interdisciplinary Care Team (ICT) under Member's direction, is responsible for developing the ICP, and is driven by and customizable according to the needs and preferences of the Member. As a provider you may be asked to be a part of the ICT.

Additional services can be requested through the Member's care coordinator anytime including during the assessment process and through the ICT process. Additional service need must be at the Member's direction and can be brought forward by the Member, the care manger, and/or the ICT team as necessary. Once an additional need is established, the care plan will be updated with the Member's consent and additional services approved. For additional information regarding MLTSS service coordination and approvals in the Member's ICP, please contact Molina at (888) 483-0760.

Transition of Care Programs

Molina has goals, processes and systems in place to ensure smooth transitions between Member's setting of care and level of care. This includes transitions to and from inpatient and residential settings (i.e., hospitals to home and nursing facility to Home).

All care coordinators are trained on the transitions of care approach that Molina follows for transitions between care settings. The care coordinators will facilitate on-site, in-person, and home-based assessments that are housed in an electronic health management platform.

Continuity of Care (COC) Policy and Requirements

Molina will allow for the safe transition of Members while adhering to minimal service disruption. In order to minimize service disruption, Molina will honor the Member's existing service plans, level of care, prior authorizations and providers (including out-of-network providers) for ninety (90) calendar days, or until the Health Plan completes an Individualized Care Plan, whichever is longer and reimburse providers at a rate no less than the current Medicaid provider rate.

Ongoing provider support and technical assistance will be provided especially to community behavioral health, LTSS providers, and out of network providers during the continuity of care period. All existing Integrated Care Plans (ICPs) and Prior Authorizations (PAs) will be honored during the ninety (90) day transition period.

A Member's existing provider may be changed during the ninety (90) day transition period only in the following circumstances: (1) the Member requests a change; (2) the provider chooses to discontinue providing services to a Member as currently allowed by Medicaid; (3) Molina or IDHW identify provider performance issues that affect a Member's health or welfare; or (4) the provider is excluded under State or Federal exclusion requirements.
Members will be advised via written notice that they have received care that would not otherwise be covered at an in-network level and will not be covered once the transition period is ended.

However, Molina will make every effort to contract with these out-of-network providers so as to avoid any disruption in care. Out-of-network providers who are providing services to Members during the initial continuity of care period shall be contacted to provide them with information on becoming credentialed, in-network providers. If the provider chooses not to join the network, or the Member does not select a new in-network provider by the end of the ninety (90) days, Molina will work with the Member in selecting an in-network provider.

Members in a Nursing Facility (NF) or in an intermediate care facility for persons with intellectual disabilities (ICF/ID) at the time of Molina MLTSS enrollment may remain in that NF or ICF/ID as long as the Member continues to meet nursing facility level of care, unless they, or their family or authorized representative, prefer to move to a different NF or ICF/ID or return to the community. The only reasons for which Molina may require a change in NF or ICF/ID facility is if (1) Molina or IDHW identify provider performance issues that affect a Member's health or welfare; or (2) the provider is excluded under State or Federal exclusion requirements.

For additional information regarding continuity of care and transition of MLTSS members, please contact Molina at (844) 239-4913.

Assessment, Care Plan Development and Self-Directed Services

The following are assessment timeframes:

- Comprehensive Health Risk Assessments within required timeframes based on Member risk factors, and at least once every twelve (12) months thereafter):
  - High risk – within thirty (30) days of enrollment.
  - Medium risk – within sixty (60) days of enrollment.
  - Low risk – within ninety (90) days of enrollment.

An Individualized Care Plan shall be developed for each Member no later than one-hundred-twenty (120) calendar days from the time of enrollment or within thirty (30) calendar days of the completion of the Comprehensive Health Risk Assessment, whichever occurs first.

Members have the choice of how their services are delivered through various models, which may include self-direction.

Molina will provide information, choice, and supports to educate and assist the Member to promote self-direction of A&D Waiver services. Self- direction of the following services through Personal Assistance Agencies (PAA) functioning as Fiscal Intermediary (FI) Agencies are listed below:

- Companion Services
- Skilled Nursing
- Consultation
- Attendant Care

- Homemaker
- Chore Service

Continuity of Care (COC) Process and Requirements for Non-Par Providers

Overview

Molina will allow for the safe transition of Members while adhering to minimal service disruption. In order to minimize service disruption, Molina will honor the Member's existing service plans, level of care, prior authorizations and providers (including out-of-network providers) for ninety (90) calendar days, or until the Health Plan completes an Individualized Care Plan, whichever is longer and reimburse providers at a rate no less than the current Medicaid provider rate.

Ongoing provider support and technical assistance will be provided especially to community Behavioral health, LTSS providers, and out of network providers during the continuity of care period. All existing Integrated Care Plans (ICPs) and Prior Authorizations (PAs) will be honored during the ninety (90) day transition period.

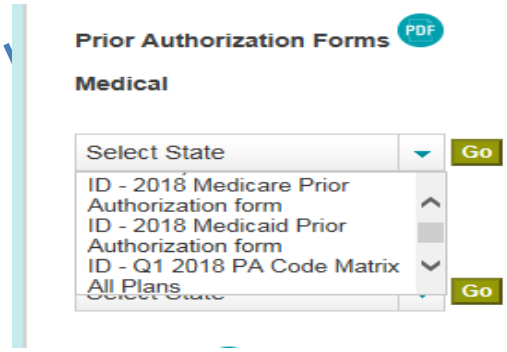
Process to Receive Prior Authorization

Molina Utilization Management (UM) receives information request for services of a non-participating provider in the following ways:

1. IDHW sends authorization to Molina UM
   - Once processed, Molina UM will then send an Authorization number to the Provider by phone or fax.

2. Non participating provider submits authorization form found on Molina Provider website:
   http://www.MolinaHealthcare.com/providers/common/medicare/Pages/medicare.aspx
   Fax: (844) 251-1450

   - Once processed and approved provider receives authorization number from Molina UM by phone or fax



Notification to Provider

- Molina will notify Provider by letter acknowledging services being provided.
- Education provider on submitting claims, and contracting with Molina.

Submitting Claims to Molina

Covered services will be reimbursed at a non-participating rate of one-hundred percent (100%) of Medicare/one-hundred percent (100%) of Medicaid. Please follow the instructions below to submit a claim.
Claims may be submitted by mail or electronic format to:

- Mailing Address: PO Box 22630, Long Beach, CA, 90801
- Electronic Data Interchange (EDI) Number: 61799

Become Contracted with Molina

We would like to invite you to join our network and be a Participating Provider for our members.

Please contact us at MHUProviderContracting@MolinaHealthcare.com to receive a contract packet which will include the contract, and further instructions on how to become fully credentialed and contracted.

Credentialing

Molina uses a standard credentialing and recredentialing process consistent with State required policies for LTSS providers. Molina also ensures that network providers have physical access, reasonable accommodations and accessible equipment for Members with physical or mental disabilities. Detailed information about Molina's credentialing/recredentialing process is available in the Credentialing section of this Provider Manual.

Appeals, Grievances, and State Hearings

Molina maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased and appropriate resolutions. Molina Members, or their authorized representatives, have the right to voice a grievance or submit an appeal through a formal process.

All appeals and grievances will be logged in an IDHW-approved database such that the IDHW may have access to real-time data regarding grievances and appeals filed with Molina.

Molina ensures that Members have access to the appeal process, by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner; including oral, written, and language assistance if needed. Grievance information is also included in the Member Handbook.

Member Grievances

Molina will have a system in place for addressing Member grievances; including grievances regarding reasonable accommodations and access to services under the Americans with Disabilities Act In accordance with IDHW. Written records of all grievance activities will be maintained and Molina will notify IDHW of all internal grievances.

Members may authorize a designated representative to act on their behalf (hereafter referred to as "representative"). The representative can be a friend, a family member, health care provider, or an attorney. An authorized Representative Form can be found on Molina's member website.

Members may file a grievance by calling Molina's Member Services Department at (844) 239-4914. TTY users call (800) 346-4128.

Members may also submit a grievance in writing to:

Molina Healthcare of Idaho, Inc.
Attention: Appeals and Grievance Department
7050 Union Park Center, Suite 200
Midvale, UT 84047

Molina will investigate, resolve and notify the Member or representative of the findings. Every attempt will be made to resolve a grievance at the time of a call. However, if a grievance is unable to be resolved immediately, it will be resolved as expeditiously as possible, but no later than the following timeframes:

- Health Plan level Appeals. Thirty (30) calendar days from the date the Health Plan receives the Appeal.
- Expedited Health Plan level Appeals. A maximum of three (3) business days after the Health Plan receives the Appeal.
- Extension of timeframes. Health Plan may extend the timeframes for Health Plan level Appeals and Grievances by up to fourteen (14) calendar days if the member requests the extension, or if the Health Plan shows that there is a need for additional information and the delay is in the member's interest.

If the grievance resolution affirms the denial, reduction, suspension, or termination of a Medicaid-covered service, or if the resolution permits the billing of a Member due to Molina's denial of payment for that service, Molina will notify the Member of their right to request a State hearing.

Member Appeals

Appeals are the request for a review of an action. The Member or their representative acting on their behalf has the right to appeal Molina's decision to deny a service. For

Member appeals, Molina must have written consent from the Member authorizing someone else to represent them.

The Member or the Member's representative has sixty (60) calendar days from the date the Notice of Action was mailed to file an Appeal. A Grievance may be filed at any time. If Molina rules against the Member, he/she may appeal the action through the State fair hearing process after exhausting Molina Healthcare's appeals process.

All appeals received will be kept confidential except as needed to resolve the issue and respond to the Member or representative. Additional information on Members' appeals and grievances are available in the Molina Members Handbook.

Members Right to a State Fair Hearing

Members are notified of their right to a State hearing in all of the following situations:

- A service denial (in whole or in part).
- Reduction, suspension or termination of a previously authorized service.
- A Member is being billed by a Provider due to a denial of payment and Molina upholds the decision to deny payment to the Provider.

Provider Claims Dispute (Adjustment Request)

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

Molina Healthcare of Idaho, Inc.
Attention: Provider Claims Disputes
7050 Union Park Center –Suite 200
Midvale, UT 84047

Provider Complaints

Providers must follow the current Conditions of Participation and Service Specification requirements of the Medicaid Waiver (s) for which they are certified/approved. Each entity that pays claims will review provider's documentation to verify that services authorized and paid for are actually provided. Providers must work with the Molina first before submitting complaints to the state agency.

Critical Incident Reporting and Management

Molina participates in efforts to prevent, detect and remediate critical incidents, based on requirements for home and community-based waiver programs and responds to critical incidents within twenty-four (24) hours. Molina will comply with Idaho Code § 39-53, "Adult Abuse, Neglect and Exploitation Act" in all aspects of its Critical Incident Resolution and Tracking System.

It is important that our providers report any activities that seem out of the norm. It is imperative that we ensure our Members are protected and safe from harm. Critical incidents occur in a NF, inpatient behavioral health or home-and community-based service delivery setting (e.g., an adult day health care center, a Member's home or any other community-based setting), among other settings will be reported in a timely manner.

The following lists of "incidents" are required to be reported in a timely manner:

- Abuse: The infliction (by one's self or others) of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm, pain or mental anguish.
    - Physical abuse is the intentional use of physical force resulting in injury, pain or impairment. It includes pushing, hitting, slapping, pinching and other ways of physically harming a person. It can also mean placing you in incorrect positions, force feeding, restraining or giving medication without your knowledge.
    - Emotional abuse occurs when a person is threatened, humiliated, intimidated or otherwise psychologically hurt. It includes the violation of your right to make decisions and/or the loss of your privacy.
    - Sexual abuse includes rape or other unwanted, nonconsensual sexual contact, but it can also mean forced or coerced nudity, exhibitionism and other non-touching sexual situations, regardless of the age of the perpetrator.
- Neglect: When someone has a duty to do so, but fails to provide goods, services, or treatment necessary to assure your health and welfare.
- Exploitation: the unlawful or improper act of using a Member or a Member's resources for monetary or personal benefit, profit, or gain.
- Misappropriation: depriving, defrauding or otherwise obtaining the money, or real or personal property (including medication) belonging to you by any means prohibited by law.
- Death of a Member.

The maximum timeframe for reporting an incident shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within twenty four (24) hours. Molina Healthcare will respond within twenty-four (24) hours to Critical Incidents with the following timeframes, based on the criteria:

- Reports of abuse, neglect, or exploitation must be reported immediately to Adult/Child Protection and to the appropriate law enforcement agency within four (4) hours;
- Report of any other Critical Incident that may impact the health and/or safety of the Member must be responded to as appropriate to ensure the health and safety of the Member;

- May result in an interim resolution/response until a permanent resolution/response can be accomplished.

Fighting Fraud, Waste and Abuse

Proper Member identification is vital to reduce fraud, waste and abuse (FWA) in government health care programs. The best way to verify a Member's identity is to obtain a copy of the Member's ID card and a form of picture ID. Do you have suspicions of Member or Provider fraud? The Molina AlertLine is available to you twenty-four (24) hours a day, seven (7) days a week, even on holidays at (866) 606-3889. Reports are confidential, but you may choose to report anonymously.

Molina complies with all Federal and State requirements regarding fraud and abuse, including, but not limited to, Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

Molina will report to the IDHW's Contract Monitor any facts regarding irregular activities or practices that may conflict with Federal or State rules and regulations discovered during the performance of activities under the contract. Such information may also need to be reported to the Medicaid Fraud Control Unit (MFCU) and the Medicaid Program Integrity Unit, as appropriate.

Additional information of Fraud, Waste and Abuse is available in the Compliance section of this Provider Manual.

Claims for LTSS Services

Providers are required to bill Molina Healthcare of Idaho, Inc. for all LTSS services (including Aged and Disabled waiver services) through EDI submission, through the Web Portal and/or via paper claims. After registering on the Molina Web Portal a provider will be able to check eligibility, claim status and create/submit claims to Molina Healthcare. To register please visit: Provider Self Services Web Portal

Providers may submit EDI claims using Change Healthcare (CHC), Molina's EDI Clearinghouse with the unique Molina Payer ID.
Out-of-network providers will continue to bill with their assigned IDHW provider number to receive payment.

Billing Molina

For reference, the Home and Community Based Services (HCBS) Codes for Idaho are available in Appendix 1 of this Provider Manual.

For reference, the Nursing Facility Billing Guidance for Idaho is available in Appendix 2 of this Provider Manual.

Atypical Providers

The Centers for Medicare & Medicaid Services (CMS) defines atypical providers as providers that do not provide health care. Examples of Atypical providers include taxi services, home and vehicle modifications, insect control, habilitation and respite services, etc. Although they are not required to register for an NPI, these providers perform services that are reimbursed by Molina.

Atypical providers are required to use their unique 8-digit Idaho Medicaid Provider number assigned at time of enrollment given to them by the state of Idaho to take the place of the NPI.

Claims Submission: Web-Portal

We encourage our MLTSS providers to utilize the Molina web portal to submit claims and will allow for faster reimbursement to the provider. Please see the Claims Submission Section or the Web-Portal Quick Reference Guide for further details. You may also contact your Provider Services Representative for additional information. http://www.MolinaHealthcare.com/providers/common/medicare/PDF/corp-provider-quick-reference-guide-2017

Timely Filing Limit

For an Idaho Medicaid claim to be considered as filed on a timely basis, the complete claim must be submitted within twelve (12) months (three-hundred-sixty-five [365] days) of the start date of service or in the case of a date range from the start date of service.

Molina shall pay or deny ninety percent (90%) of clean claims within thirty (30) calendar days of receipt of the claim.

Molina shall pay or deny ninety-nine percent (99%) of all clean claims within ninety (90) calendar days of receipt of the claim.

If the claim is a paper claim, Molina shall pay or deny ninety percent (90%) of clean claims within forty-five (45) calendar days of receipt of the claim.

Billing Molina Members

Molina shall require, as a condition of payment, that the Provider accept the amount paid by the Health Plan, or appropriate denial made by the Health Plan or, if applicable, payment by the Health Plan that is supplementary to the Member's third party payer, plus any applicable amount of cost sharing or patient liability responsibilities due from the Member as payment in full for the service. Providers cannot bill Members for any

other amount other than the applicable amount of cost sharing or patient liability responsibilities.

Member Responsibility

IDHW will provide Molina with the amount of cost sharing or patient liability responsibilities, if any, that it may assess to each Member. Molina shall ensure that if cost sharing is required for Medicaid services, it is only to the extent that cost sharing or patient liability responsibilities are required for those services by IDHW in accordance with applicable Federal and State statutes and regulations. LTSS Long-Term Care facility providers are responsible for collecting patient liability amounts from Members receiving services. Similarly, Home and Community Based providers are responsible for collecting applicable co-payments for covered services. Molina will apply the appropriate cost sharing or patient liability responsibilities amount to LTSS claims received prior to reimbursement to Providers.

19. Appendix 1: Home and Community Based Services (HCBS) Codes

Service Code	Modifiers	BBRD
S5100		Adult Day Health
S5140		Adult Residential Care
T1019		
S5100		
H2011		
S5125		Attendant Care Services
S5120		Chore Services
S5135		Companion Services
S5115		Consultation
T2021		Day Habilitation
S5165		Environmental Accessibility Adaptations
S5170		Home Delivered Meals
S5130		Homemaker Services
A0080		Non-Medical Transport
A0080	76	
A0080		
A0110		
T2001		
S5160		Personal Emergency Response System
S5161		
G9002		Personal Care Services
T1001		
G9001		
H2020		
T1019		
H2015	HQ	Residential Habilitation
H2015		
0930T		
H2016		
T1005		Respite
T1002		Skilled Nursing Services
T1001		
T1003		
E1399		Specialized Medical Equipment and Supplies

Service Code	Modifiers	BBRD
H2023		Supported Employment
G9002		Targeted Service Coordination
G9002	HM	
G9007		
H2011		
H2011	HM	

20. Appendix 2: Nursing Facility Billing Guidance

Revenue Code	Description
0100	Inpatient days (NF, ICF/ID, or swing bed)
0101	All Inclusive R&B LTC (For Special Rate or participant Specific Pricing)
0183	LOA (NF therapeutic leave to home)
0189	ICF/ID LOA (Other Leave of Absence)

Bill Types	Description
0211	Skilled Nursing - Inpatient (Admit - Through - Discharge Claim)
0212	Skilled Nursing - Inpatient (Interim - First Claim)
0213	Skilled Nursing - Inpatient (Interim - Continuing Claim)
0214	Skilled Nursing - Inpatient (Interim - Last Claim)
0215	Skilled Nursing - Inpatient (Late Charge Only)
0217	Skilled Nursing - Inpatient (Adjustment/Replacement of Prior Claim)

21. Frequently Asked Questions (FAQ)

1. **Where is the manual located?**

The Molina Healthcare of Idaho, Inc. Provider Manual is located on our website: www.MolinaHealthcare.com/providers

2. How do I submit a claim?

Molina requires Participating Providers to submit Claims electronically (via a clearinghouse or Molina's Provider Portal).

- Access the Provider Portal (https://provider.MolinaHealthcare.com)
- EDI Payer ID number 61799
- Paper Claims: PO Box 22811, Long Beach, CA 90801

(See the Claims and Compensation section of this Provider Manual)

3. Where do I go if I have a claims question?

To verify the status of your claims, please use Molina's Provider Portal. For other claims questions contact Provider Services.

Web Portal	https://provider.MolinaHealthcare.com
ID-Medicare Options Plus HMO	(844) 560-9811
ID-Medicare Options Plus HMO-SNP	(844) 239-4913

(See the Contact Information for Providers section of this Provider Manual)

4. What tools are available on the website?

The Provider Portal is available to use twenty-four (24) hours a day, seven (7) days a week. A provider can accomplish a number of tasks, including:

- Check Member eligibility.
- Submit and check the status of your claims.
- Submit and check the status of your service or request authorizations.
- View your HEDIS scores.
- And more.

6. How do I sign up for the Provider Portal?

A Provider can sign up for the Provider Portal online. You can view the **Quick Reference Guide** for instructions on "How to Register" on pg. 3 of the Quick Reference Guide.

The Provider will need their Molina Provider ID # for All Lines of Business they are participating in. These numbers are by group TIN, then Group NPI. (There are usually 2 numbers EX: QMP00000111)

7. Molina Health Plan the same as MMS?

No, they are different.

Molina Healthcare is the name of the company that contracts with state governments and offers a comprehensive health plan with quality benefits and programs, such as MMCP in the State of Idaho.

Molina Medicaid Solutions (MMS) Molina's Medicaid management information systems' provide the technological foundation needed by state agencies to meet current and future Medicaid Information Technology Architecture (MITA) business process and regulatory health care requirements. Molina Medicaid Solutions' fiscal agent contracts with Idaho

8. How do I submit a preauthorization?

Molina offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Molina via the Provider Portal. See Molina's Provider Web Portal Quick Reference Guide or contact your Provider Services Representative for registration and submission guidance.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Web Portal	https://provider.MolinaHealthcare.com
Telephone ID	(844) 239-4914
Fax ID	(844) 251-1450
Pre-Authorization Form and Codification List	http://www.MolinaHealthcare.com/providers/common/medicare/Pages/medicare.aspx Located under the Pre-Authorization Forms Section

(See the Contact Information for Providers section of this Provider Manual.)

9. How do I become a contracted Molina Provider?

Idaho Providers must complete a credentialing application designed to provide Molina with information necessary to perform a comprehensive review of the Provider's credentials.

Please contact Provider contracting for more information at:
MHUProviderContracting@MolinaHealthcare.Com

Or call and leave a voicemail: (844) 239-4914 (Option 4 option 6 option 1)
We return these calls within forty-eight (48) hours of receipt.

10. I have a new provider joining my practice, how do I add them to my contract?

Idaho Providers must complete an "Application to add a Practitioner" designed to provide Molina with information necessary to perform a comprehensive review of the Provider's credentials and add them to a group contract.

The application can be found on Molina's website in the Forms section:
www.MolinaHealthcare.com/providers

11. What is the difference between the two Idaho Products?

a. Molina Medicare Option HMO
   i. Medicare Advantage
b. Molina Medicare Options Plus HMO-SNP
   i. Dual Options- Both Medicare and Medicaid.
   ii. Has additional Supplemental benefits (MLTSS).
   iii. Medicare is not automatically enrolled, Member has to choose Molina as their Medicare plan when they are auto enrolled later this year.
   iv. Member can change plans every thirty (30) days.

22. Glossary of Terms

Term	Definition
Abuse	Practices that are inconsistent with sound fiscal, business, or medical practices, that result in an unnecessary cost to the government program or in reimbursement for services that are not medically necessary, or fail to meet professionally recognized standards for health care.
Advance Directive	A Member's written instructions, recognized under Law, relating to the provision of health care, when the Member is not competent to make a health care decision as determined under Law.
Affiliate	An entity owned or controlled by Health Plan or Molina Healthcare, Inc.
Agreement	Provider Services Agreement between Provider and Health Plan and all attachments, exhibits, addenda, amendments, and incorporated documents or materials.
Appeal	A complaint lodged by a Member if they disagree with certain kinds of decisions made by the health plan.
Case Management	A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to accommodate the specific health services needed by an individual.
Centers for Medicare & Medicaid Services (CMS)	The agency responsible for Medicare, and certain parts of Medicaid, CHIP, MMP, and the Health Insurance Marketplace.
Claim	A bill for Covered Services provided by Provider.
Claims Delegate	An entity that agreed to administer Claims payment for certain Covered Services on behalf of Health Plan, as defined in the contract between Health Plan and the entity.
Clean Claim	A Claim for Covered Services submitted on an industry standard form, which has no defect, impropriety, lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.
Coinsurance	The amount a Member pays for medical services after the deductible is paid. Coinsurance amounts are usually percentages of approved amounts.
Co-payment or Copay	The amount a Member pays for medical services such as a provider's visit or prescription.
Covered Services	Those health care services and supplies, including Emergency Services, provided to Members that are Medically Necessary and are benefits of a Member's Product.

Term	Definition
Cultural Competency Plan	A plan that ensures Members receive Covered Services in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds, and limited English proficiency.
Date of Service	The date on which Provider provides Covered Services or, for inpatient services, the date the Member is discharged.
Deductible	The amount a Member pays for health care or prescriptions, before the health plan begins to pay.
Disenroll	Ending health care coverage with a health plan.
Division of Financial Responsibility (DOFR)	A document whereby health plans assign the payment risk for any contract, dividing payment responsibilities among the plan itself, the contracted hospital, or a Medical Group/IPA.
Downstream Entity	Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between Health Plan (or applicant) and Provider. These written arrangements continue down to the level of the ultimate provider of both health and administrative services
Durable Medical Equipment (DME)	Purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home.
Eligibility List	A list of Members that are assigned to Primary Care Providers (PCP) through a Medical Group, IPA or Staff Model Organization.
Emergency Services/Care	Covered inpatient and outpatient services furnished by a provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.
Encounter Data	All data captured during the course of a single health care encounter that specifies: (i) the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices, and equipment associated with a Member receiving services during the encounter; (ii) the identification of the Member receiving and the provider providing the health care services during the single encounter; and, (iii) a unique and unduplicated identifier for the single encounter.
Enrollment	The process by which an eligible person becomes a Member of a managed care plan.
EOB	Explanation of Benefits.

Term	Definition
Experimental	Items and procedures determined by Medicare not to be generally accepted by the medical community.
Formulary	A list of certain prescription drugs that the health plan will cover subject to limits and conditions.
Fraud	Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. This includes any act that constitutes fraud under applicable Federal or State law.
Government Contracts	Those contracts between Health Plan and state and federal agencies for the arrangement of health care services for Government Programs.
Government Programs	Various government sponsored health products in which Health Plan participates.
Government Program Requirements	The requirements of governmental authorities for a Government Program, which includes, but is not limited to, the requirements set forth in the Government Contracts.
Grievance	A complaint about the way a Medicare health plan is giving care.
Grievance Program	The procedures established by Health Plan to timely address Member and Provider complaints or grievances.
Health Plan	Molina Healthcare of Idaho, Inc.
Health Maintenance Organization Plan	A type of Medicare Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. HMO costs may be lower than in the Original Medicare Plan.
Home Health Agency	An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.
Hospice Services	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling.
Institution	A facility that meets Medicare's definition of a long-term care facility, such as a nursing home or skilled nursing facility. Assisted or adult living facilities, or residential homes, are not included.
IPA (Independent Practice Association)	An IPA is an association of providers and other health care providers, including hospitals, who contract with HMOs to provide services to the HMO Members, but usually also see non-HMO patients.
Law	All Federal and State statutes and regulations applicable to this Agreement.

Term	Definition
Long-Term Care	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare does not pay for this type of care if this is the only care needed.
Managed Care	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare does not pay for this type of care if this is the only care needed.
Medicaid	The joint Federal-State program provided for under Title XIX of the Social Security Act, as amended.
Medically Necessary or Medical Necessity	Health care services that a health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and, (iv) not more costly than an alternative service, or site of services, at least as likely to produce equivalent results.
Medicare (Original Medicare)	A pay-per-visit health plan that lets Members go to any provider, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. Members must pay the deductible. Medicare pays its share of the Medicare approved amount, and Members pay a share (co-insurance). In some cases Members may be charged more than the Medicare-approved amount. The Original Medicare Plan has two (2) parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
Medicare Plan	A plan offered by a private company that contracts with Medicare to provide Members with all Medicare Part A and Part B benefits. In most cases, Medicare Plans also offer Medicare prescription drug coverage.
Medicare Advantage (MA) Plan	A program in which private health plans provide Covered Services through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as "Medicare"). Medicare Advantage also includes Medicare Advantage Special Needs Plans ("MA-SNP").

Term	Definition
Member	A person enrolled in a Product and who is eligible to receive Covered Services
Network	A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its Members.
Overpayments	A payment Provider receives, which after applicable reconciliation, Provider is not entitled to receive pursuant to Laws, Government Program Requirements, or this Agreement.
Participating Provider	A health care facility or practitioner contracted with and, as applicable, credentialed by Health Plan or Health Plan's designee.
Primary Care Provider (PCP)	A provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse providers, nurse midwives, or physician assistants) who manages, coordinates, and monitors covered primary care (and sometimes additional services).
Provider	The entity identified on the Signature Page of the Agreement and includes any person or entity performing Covered Services on behalf of Provider and for which: (i) an entity of the Provider bills under an owned tax identification number; and, (ii), when applicable, such person or entity has been approved by Health Plan as a Participating Provider. Each entity or person shall be considered an "Individual Provider".
Provider Manual	Health Plan's provider manuals, policies, procedures, documents, educational materials, and, as applicable, Supplemental Materials, setting forth Health Plan's requirements and rules that Provider is required to follow.
Quality Improvement Program (QI Program)	The policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.
Risk Adjustment	Payment methodology designed to pay appropriate premiums for each Molina Healthcare Medicare Member. CMS bases its premium payment according to the health status of each Member.
Service Area	The area where a health plan accepts Members. For plans that require participating doctors and hospitals to be used, it is also the area where services are provided. The plan may disenroll Members who move out of the plans service area.
Skilled Nursing Facility (SNF)	A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

Term	Definition
Skilled Nursing Facility Care	This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff and that, as a practical matter, can't be provided on an outpatient basis.
Special Needs Plan	A special type of plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, or those who reside in a nursing home.
State Children's Health Insurance Program ("SCHIP" or "CHIP")	The program established pursuant to Title XXI of the Social Security Act, as amended.
Subcontractor	An individual or organization, including Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement, including delegation activities. For the avoidance of doubt, a Subcontractor does not include Individual Providers.
TTY	A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have severe speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.
Urgently Needed Services	Care that Members get for a sudden illness or injury that needs medical care right away, but is not life threatening. PCPs generally provide urgently needed care if the Member is in a Medicare health plan other than the Original Medicare Plan. If a Member is out of the plan's service area for a short time and cannot wait until the return home, the health plan must pay for urgently needed care.
Utilization Review and Management Program ("UM Program")	The policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including, but not limited to, under-utilization and over-utilization.
Waste	Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of

Term	Definition
	poor or inefficient billing methods (e.g., coding) causes unnecessary costs to the Medicaid/Medicare programs.