MOLINA® HEALTHCARE

PROVIDER MANUAL

Molina Healthcare of Illinois, Inc.
(Molina Healthcare or Molina)

Dual Options Program
(Medicare-Medicaid Program)

2021

The Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated 11/2021

Welcome to Molina Healthcare of Illinois

Molina Healthcare (Molina) would like to thank you for participating in the care of our Members. Our Provider Manual was designed to assist you with understanding plan policies, procedures, and other protocols.

The current Provider Manual is available 24/7 in the Provider section of the Molina website, under the Manual tab. Contact your Provider Network Manager or the Provider Network Management team with any questions or concerns at **(855) 866-5462** or MHILProviderNetworkManagement@MolinaHealthcare.com.

In addition to the Provider Manual, Molina issues many important updates throughout the year. These updates and critical notifications are posted on the Provider website under the Communications tab; select News & Updates.

To receive these important notifications automatically, we recommend that you register for our Provider emails.

The quality care of our Members is our ultimate goal. Thank you for being part of the Molina family.

Molina Healthcare of Illinois Team

New and Different for 2021

This table lists some of the most noteworthy additions and updates to this Molina Dual Options Provider Manual. It does **not** list all changes. Providers should review and become familiar with the entire document.

Section	Description	Page
2. Addresses and Phone Numbers	Service Area Map	9
4. Benefit Overview	2021 Summary of Benefits	13
4. Benefit Overview	2021 Evidence of Coverage	13
4. Benefit Overview	Telehealth and Telemedicine	13
6. Quality	Behavioral Health Survey	45
6. Quality	What Can Providers Do?	46
6. Quality	Merit-based Incentive Payment System (MIPS)	46
7. Risk Adjustment Management	New Section	48
8. Cultural Competency and Linguistic Services	Nondiscrimination of Health Care Service Delivery, Section 1557 Updates	50
11. Provider Responsibilities	**COVID-19 Safety Protocols for Federal Contractors***	**98**
11. Provider Responsibilities	Cooperation Between Providers	99
11. Provider Responsibilities	National Plan and Provider Enumeration System (NPPES) Data Verification	100
11. Provider Responsibilities	Availity Provider Portal	102
11. Provider Responsibilities	Updated Language for Balance Billing	103
11. Provider Responsibilities	Maternal Care	106
12. Claims and Compensation	Telehealth Claims and Billing	112
12. Claims and Compensation	Updated Language for Balance Billing	118
13. Credentialing and Recredentialing	Uniform Credentialing and Recredentialing	120
16. Delegation	Updated Language for Delegation	132

*** Critical Update.**

Contents

1. Medicare-Medicaid Plan (MMP) Products

Medicare-Medicaid Plan (MMP)
Molina Healthcare of Illinois is participating in a multi-year demonstration program between the Centers for Medicare & Medicaid Services (CMS) and the Illinois Department of Healthcare and Family Services (HFS). This is known as the Medicare-Medicaid Alignment Initiative (MMAI) in Illinois. This program will benefit our Members by providing the convenience of coordinated care with one primary care Provider and one ID card.

Molina Healthcare's Medicare-Medicaid Plan (MMP) is called Molina Dual Options.

2. Addresses and Phone Numbers

Molina Healthcare of Illinois, Inc.
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Provider Network Management Department
The Provider Network Management department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting, and training. The department has Provider Network Managers who serve all of Molina's Provider Network.

Provider Email	Phone
MHILProviderNetworkManagement@MolinaHealthcare.com	(855) 866-5462

Member Services Department
The Member Services department handles all telephone and written inquiries regarding Member claims, benefits, eligibility/identification, pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available seven days a week, from 8 a.m. to 8 p.m., Central Time, excluding holidays. Eligibility verifications can be conducted at your convenience via the Provider Portal: Provider.MolinaHealthcare.com.

Phone	Hearing Impaired (TTY/TDD)
(877) 901-8181 (English & Spanish)	711

Claims Department
Molina strongly encourages Participating Providers to submit claims electronically (via a clearinghouse or the Provider Portal).

- Access the Provider Portal
- EDI Payer ID number 20934

To verify the status of your claims, please use the Provider Portal. For other claims questions, contact Provider Network Management.

Provider Portal	Phone
Provider.MolinaHealthcare.com	(855) 866-5462

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

Address	Fax
Molina Healthcare of Illinois, Inc. Bin 88826 Milwaukee, WI 53288-0826	(855) 260-8740

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 submitting 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.

Phone	Website	Address
(866) 606-3889	MolinaHealthcare.alertline.com	Confidential Compliance Official Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802

Credentialing Department

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three years or sooner, depending on Molina's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network.

Phone	Fax	Address
(855) 866-5462	(855) 502-4962	Credentialing Molina Healthcare of Illinois, Inc. 1520 Kensington Rd., Suite 212 Oak Brook, IL 60523

Nurse Advice Line

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

Nurse Advice Line (HEALTHLINE) 24 hours per day, 365 days per year	
English Phone - (888) 275-8750	**English TTY** – (888) 735-2929
Spanish Phone - (866) 648-3537	**Spanish TTY** – (866) 833-4703

Health Care Services Department

The Health Care Services (formerly Utilization Management) department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The Health Care 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 Authorizations/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 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 electronic Prior Authorizations/Service Requests submission options:

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

Provider Portal	Phone
Provider.MolinaHealthcare.com	(866) 409-2935

Health Management Department
Molina's Health Management Programs will be incorporated into the Member's treatment plan to address the Member's health care needs.

Phone	TTY/TDD
Member Services (877) 901-8181 (English & Spanish)	711

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

Phone	TTY/TDD
Member Services (877) 901-8181 (English & Spanish)	711

Pharmacy Department
Pharmacy services are covered through CVS. A list of in-network pharmacies is available on the MolinaHealthcare.com website or by contacting Molina's pharmacy services.

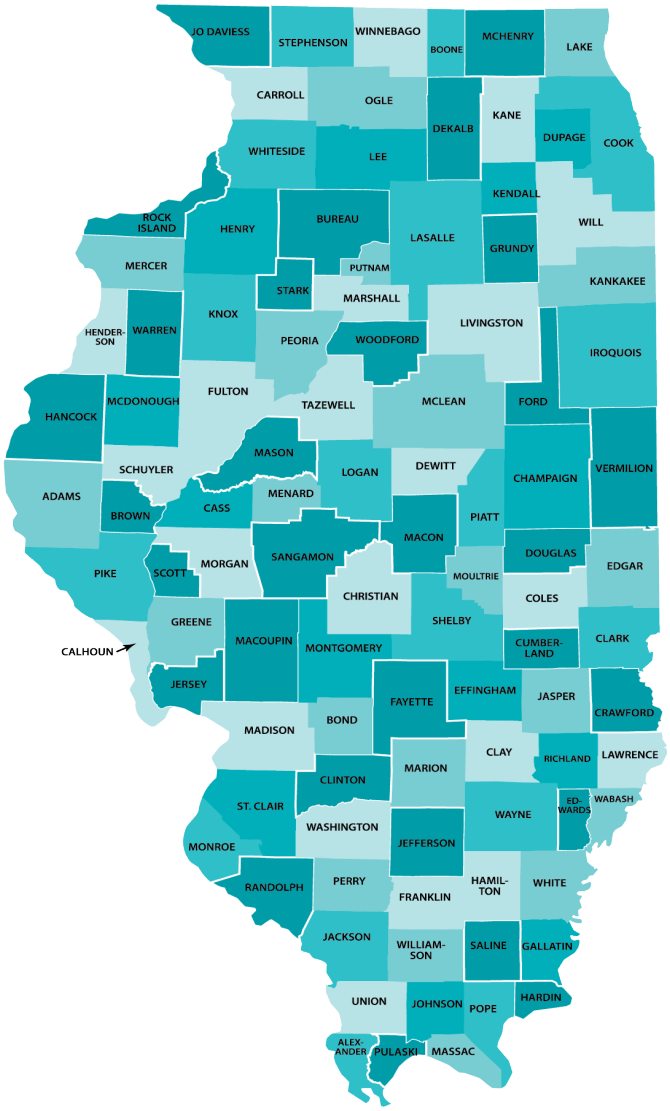
Phone	TTY/TDD
(855) 866-5462	711

Quality Improvement
Molina maintains a Quality Improvement department to work with Members and Providers in administering the Molina Quality Improvement Program.

Phone	Fax
(855) 866-5462	(855) 556-2074

Molina Healthcare of Illinois, Inc. Service Area

As of July 1, 2021, Molina Healthcare of Illinois provides Medicaid HealthChoice, MMAI (MMP Duals), and MLTSS services to all 102 Illinois counties.



3. Eligibility and Enrollment in Molina Dual Options Plans

Enrollment Information
All Members of the Molina Healthcare Dual Options Plan are full-benefit dual eligible (i.e., they receive both Medicare and Medicaid). Centers for Medicare & Medicaid Services (CMS) rules state that these Members may enroll or disenroll throughout the year.

Members who wish to enroll in Molina Medicare Advantage Plans must meet **all of** the following eligibility criteria:

- Have both Medicare Part A and enrolled in Medicare Part B.
- Permanently reside in Molina's geographic service area, which includes the following counties: Refer to Service Area Map on page 7.
- 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.
- For Dual Eligible Special Needs Plans, is entitled to Medicaid benefits as defined by the State of Illinois.

Furthermore, Molina does not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in Chapter 2 of the Medicare Managed Care Manual.

Member Toll-Free Telephone Numbers
Members may call our Member Services department toll free at **(877) 901-8181** from 8 a.m. to 8 p.m. Central Time seven days a week, or TTY/TDD 711 for persons with hearing impairments.

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 and 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 Dual Options Member to disenroll except when the Member has:

- Permanently moved outside Molina's service area.
- Lost Medicaid eligibility (for dual-eligible enrolled in Molina Dual Eligible 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 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.
- Other means of notification 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 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 in a timely manner, before the termination of the plan.
- 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

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.

4. Benefit Overview

Questions about Molina Dual Options Benefits
If there are questions as to whether a service is covered or requires Prior Authorization (PA), please contact Molina's Member & Provider Contact Center toll free at **(888) 858-2156** seven days a week from 8 a.m. to 8 p.m. Central Time, or TTY/TDD 711 for persons with hearing impairments.

Link to Summary of Benefits
The following web link provides the Summary of Benefits for the Molina Dual Options plan in Illinois: molinahealthcare.com/Members/il/en-us/mem/duals/~/media/Molina/PublicWebsite/PDF/Members/il/en-US/Duals/IL-2021-MMP-SB-EN-508.pdf.

Link to Evidence of Coverage
Detailed information about benefits and services can be found in the Evidence of Coverage booklets provided to each Molina Member.

The following web link provides the Evidence of Coverage for the Molina Dual Options plan in Illinois: molinahealthcare.com/Members/il/en-us/mem/duals/resources/info/~/media/Molina/PublicWebsite/PDF/Members/il/en-US/Duals/IL-2021-MMP-EOC-EN-508.pdf.

Note: 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.

Obtaining Access to Certain Covered Services
Telehealth and Telemedicine Services
Molina Members may obtain Covered Services from Participating Providers, through the use of Telehealth and Telemedicine services. Not all Participating Providers offer these services. The following additional provisions apply to the use of telehealth and telemedicine services:

- Services must be obtained from a Participating Provider.
- Services are meant to be used when care is needed now for non-emergency medical issues.
- Services are a method of accessing Covered Services and **not** a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Services do not include texting, facsimile, or email only.
- Services include preventive and/or other routine or consultative visits during a pandemic.
- Member cost-sharing associates to the Schedule of Benefits based upon the Participating Provider's designation for Covered Services (i.e., primary care, specialist, or other practitioner).

- Covered Services provided through store-and-forward technology, must include an in-person office visit to determine diagnosis or treatment.

Upon at least ten (10) days prior notice to Provider, Molina shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of Molina. Provider shall make its personnel reasonably available to answer questions from Molina regarding telehealth operations.

For additional information on telehealth and telemedicine claims and billing, please refer to the Claims and Compensation section of this Provider Manual.

Supplemental Services
Molina offers the following supplemental services benefits.

Service	Vendor Name & Address	Telephone
Dental	Avēsis	(800) 327-4462
Vision	Avēsis	Medicaid (866) 857-8124 MMP/Duals (855) 704-0433
Transportation	MTM Inc. (non-emergency transportation)	HealthChoice Illinois: (844) 644-6354 MMP: (844) 644-6353 Schedule rides for Members: (855) 740-3105

5. 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 Programs are when an individual is living in a facility-based care setting (such as a nursing home or intermediate care facility).
- Home and Community-Based Services Programs provide alternatives to living in facility-based care settings.

These programs empower consumers to take an active role in their health care and to remain in the community. The programs serve older adults or people with disabilities.

Molina understands the importance of working with our Providers and Community Based Organizations (CBOs) in your area to ensure our Members receive MLTSS services that maintain their independence and ability to remain in the community.

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 services to Members of the following waiver programs:

- Persons who are elderly.
- Persons with disabilities.
- Persons with HIV/AIDS.
- Persons with brain injury.
- Supportive living facility.

Services offered under these waivers are designed to assist Members maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in their home or a cost-effective home-like setting. Services for eligible Members are provided in the Member's home or assisted living facility. These waiver programs provide 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
Adult Day Service—Provides direct care and supervision of adults in a community-based setting for the purpose of providing personal attention and promoting social, physical, and emotional well-being in a structured setting.

Adult Day Health Transportation—Provides transportation from a Member's home to the adult day health facility. Does not include transportation to any other service or location.

Day Habilitation—Assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills in a non-residential setting, separate from the home or facility in which the Member resides. The focus is to enable the Member to attain or maintain his or her maximum functional level. Day habilitation shall be coordinated with any physical, occupational, or speech therapies. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Environmental Accessibility Adaptations—Provides physical adaptations to the home required by the Member's Care Plan, which are necessary to ensure the health, welfare, and safety of the individual, or which enable the Member to function with greater independence in the home, and without which the Member would require institutionalization.

Home Delivered Meals—Prepared food brought to the Member's residence that may consist of a heated luncheon meal and/or a dinner meal that can be refrigerated and eaten later.

Homemaker—This service pays two (2) different prices: one for agencies that do not pay for employee insurance and one for agencies that do. The Provider information regarding which agency will pay employee insurance and which agency will not pay employee insurance will be on the waiver-approved Provider list that Molina Healthcare will receive from the state. Homemaker service is defined as general non-medical support by supervised and trained homemakers. Homemakers are trained to assist Members with their activities of daily living, including personal care, as well as other tasks such as laundry, shopping, and cleaning.

Personal Emergency Response System (PERS)—PERS is an electronic device that enables certain Members at high risk of institutionalization to secure 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 the button is activated. PERS services are limited to those Members who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Respite—Respite services provide relief for unpaid family or primary care givers who are currently meeting all service needs of the Member. Services are limited to individual Provider, homemaker, nurse, adult day care, and provided to a Member to aid his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.

Skilled Nursing Services RN/LPN—Service provided by an individual that meets Illinois licensure standards for nursing services and provides shift nursing services.

Specialized Medical Equipment and Supplies—Specialized medical equipment and supplies includes devices, items, and appliances that enable the Member to perform

Activities of Daily Living (ADL). Limit: Items over $500 will require three competitive bids.

Supported Employment—Provides supported employment services that consist of intensive, ongoing supports that enable Members, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting. It may include assisting the Member to locate a job or develop a job on behalf of the Member and is conducted in a variety of settings, including work sites where persons without disabilities are employed.

Personal Care Services (Individual Provider)—A self-directed service reimbursed by HFS. Individual Providers provide assistance with eating, bathing, personal hygiene, and other Activities of Daily Living. This service may also include such housekeeping chores as bed making, dusting, and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the consumer, rather than the Member's family. Personal care services are a covered benefit for the following waivers: people with disabilities, HIV/AIDS, and traumatic brain injury.

Home Health Aide—Provides services by an individual that meets Illinois licensure standards for a Certified Nursing Assistant. Services provided are in addition to any services provided through the state plan.

Nursing, Intermittent—Nursing services that are within the scope of the state's Nurse Practice Act and are provided by a registered professional nurse or a licensed practical nurse licensed to practice in the state. Nursing through the HCBS Waiver focuses on long-term habilitative needs rather than short-term acute, restorative needs. HCBS waiver intermittent nursing services are in addition to any Medicaid state plan nursing services for which the Member may qualify.

Therapies—Service provided by a licensed therapist that meets Illinois standards. Services are in addition to any Medicaid state plan services for which the Member may qualify. Therapies through the waiver focus on long-term habilitative needs rather than short-term acute, restorative needs.

Prevocational Services—Prevocational services are aimed at preparing a Member for paid or unpaid employment but are not job-task oriented. This can include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Prevocational services are provided to Members expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Assisted Living (Supportive Living)—The Supportive Living Program serves as an alternative to Nursing Facility (NF) placement, providing an option for seniors 65 years of age or older and persons with physical disabilities between the ages of 22 and 64 who require assistance with activities of daily living, but not the full medical model available through a nursing facility. Members reside in their own private apartment with

kitchen or kitchenette, private bath, individual heating and cooling system, and lockable entrance.

Behavioral Health Services (M.A. and Ph.D.)—Remedial therapies to decrease maladaptive behaviors and/or to enhance the cognitive functioning of the Member to increase their capacity for independent living.

MLTSS Services by Waiver Program

Benefit	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility
Adult Day Health (ADH)	X	X	X	X	
Adult Day Health (ADH) Transportation	X	X	X	X	
Assisted Living (Supportive Living)					X
Automatic Medication Dispenser (AMD)	X				
Behavioral Health Services (M.A. and Ph.D.)				X	
Day Habilitation				X	
Environmental Accessibility Adaptations		X	X	X	
Home Delivered Meals		X	X	X	
Home Health Aide		X	X	X	
Homemaker Services	X	X	X	X	
Nursing, Intermittent		X	X	X	
Personal Care Services (Individual Provider)		X	X	X	
Prevocational Services				X	
Respite		X	X	X	
Skilled Nursing Services (LPN)		X	X	X	
Skilled Nursing Services (RN)		X	X	X	
Specialized Medical Equipment and Supplies		X	X	X	
Supported Employment				X	

Benefit	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility
Therapies		X	X	X	

Getting Care, Getting Started
Molina Care Coordinators will engage with Members and routinely assess for barriers and opportunities to coordinate medical, behavioral health, and MLTSS services. Specifically, along with providing the fully integrated Individualized Plan of Care (IPoC), the Care Coordinator will provide verbal, written, and/or alternate format information on:

- 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's name, 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 Members:

- MLTSS service coordination.
- Care and Service Plan review.
- Crisis intervention.
- Event-based visits.
- Institution-based visits.
- Service management.
- Medicaid resolution.
- Assessment of MLTSS need.
- Member education.

Molina will work closely with the various Community Based Organizations (CBOs) for Home and Community-Based Services (HCBS) to ensure that the Member is getting the care that he or she needs.

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.

Care Management Team, Integrated Care Team, Interdisciplinary Care Team (ICT)
All MLTSS Members will receive care coordination and be assigned a Care Coordinator from Molina.

The Care Management team for MLTSS will include at a minimum the Member and/or his/her authorized representative, Care Coordinator, and PCP.

The patient-centered Integrated Care Team (ICT) will include at minimum the Member and/or his/her authorized representative, Care Coordinator, and anyone a Member requests to participate. ICT Members may also include MLTSS Providers (e.g., Services Facilitator, adult day health care center staff, assistive technology, transition coordinator, nursing facility staff, etc.), PCP, specialist(s), behavioral health clinician, targeted care 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
MLTSS services to be covered by Molina will require coordination and approval.

The Individualized Care Plan (ICP) includes the consideration of medical, behavioral, and long-term care needs of the Member identified through a patient-centered assessment process. The ICP includes informal care, such as family and community supports. Molina Healthcare of Illinois will ensure that a patient-centered service plan is implemented for the Member in compliance with the Department of Health and Human Services HCBS final rule section 441.301.

A patient-centered service plan means that the plan documents the amount, duration, and scope of the Home and Community-Based Services. The service plan is patient-centered and must reflect the services and supports that are important for the Member to meet his/her needs, goals, and preferences that are identified through an assessment of functional need. The service plan will also identify what is important regarding 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 the end date of any existing Service Authorization (SA) or within the state-specific time frames for initial assessments and reassessments. 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 Integrated Care Team (ICT) under the 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 any time, including during the assessment process and through the ICT process. Additional services needed 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 ICP 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 **(877) 901-8181**.

Transition of Care (TOC) Programs
Molina has goals, processes, and systems in place to ensure smooth transitions between a Member's setting of care and level of care. This includes transitions to and from inpatient settings (i.e., 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 can use tablet technology housed in an electronic health-management platform to facilitate on-site, in-person, and home-based assessments.

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, and Providers (including out-of-network Providers) for 90 days.

Ongoing Provider support and technical assistance will be provided, especially to community behavioral health, MLTSS Providers, and out-of-network Providers during the COC period. All existing Integrated Care Plans (ICPs) and Service Authorizations (SAs) will be honored during the transition period of 90 days.

A Member's existing Provider may be changed during the 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 HFS identifies Provider performance issues that affect a Member's health or welfare, or (4) the Provider is excluded under state or federal exclusion requirements.

Out-of-network Providers who are providing services to Members during the initial COC 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 90-day transition period, Molina will work with the Member to select an in-network Provider.

Members in a Nursing Facility (NF) at the time of Molina MLTSS enrollment may remain in that NF as long as the Member continues to meet Nursing Facility level of care, unless they, their family, or authorized representative prefer to move to a different NF or return to the community. The only reasons for which Molina may require a change in NF is if (1) Molina or HFS identifies Provider performance issues that affect a Member's health or welfare, or (2) the Provider is excluded under state or federal exclusion requirements.

Reassessments will be completed as necessary and IPoCs updated. Molina will review IPoCs of high-risk (Level 3) Members at least every 30 days, and moderate-risk (Level 2) Members at least every 90 days, and conduct reassessments as needed based upon such reviews. At a minimum, a health-risk reassessment will be conducted annually for each Member who has an IPoC. In addition, a face-to-face health-risk reassessment will

be conducted for Members receiving HCBS waiver services or residing in NFs each time there is a significant change in the Member's condition or a Member requests reassessment. The updated IPoCs will be given to Providers that are involved in providing Covered Services to Members within no more than five business days.

For additional information regarding Continuity of Care and transition of MLTSS Members, please contact Molina at **(877) 901-8181**.

Members have a choice of how their services are delivered through various models, which may include consumer direction. The Molina Care Coordinator will work with the Member or his/her designee to ensure that the Member meets the criteria for consumer direction.

Appeals, Grievances, and State Hearings
Molina maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased, and appropriate resolutions. Molina MLTSS Members, or their authorized representative(s), have the right to voice a grievance or submit an appeal through a formal process.

Molina ensures that Members have access to the appeal process by providing assistance throughout the 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 Illinois Department of Healthcare and Family Services (HFS). Written records of all grievance activities will be maintained, and Molina will notify HFS of all internal grievances if required.

Members may authorize a designated representative to act on their behalf (hereafter referred to as "representative"). The representative can be a friend, family member, health care Provider, or 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 **(877) 901-8181** (TTY for the hearing impaired 711).

Members may also submit a grievance in writing to:

Molina Healthcare of Illinois, Inc.
Attention: Appeals and Grievance Department
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

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 time frame: 90 days from receipt of the grievance.

If the grievance resolution affirms the denial, reduction, suspension, or termination of a 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 his/her right to request a state hearing.

Member Appeals
Appeals are the request for a review of an action. The Member or the representative acting on behalf of the Member 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 him/her.

All grievances 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 is available in the Molina Member 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 shall be classified as a Provider Dispute and shall be sent to the following address:

Molina Healthcare of Illinois, Inc.
Attention: Provider Claims Disputes
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

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 the Provider's documentation to verify that services authorized and paid for are actually provided. Providers must work with 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.

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 that occur in a nursing facility, 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 a person in incorrect positions, force-feeding, restraining, or giving medication without 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 a person's 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 a person by any means prohibited by law.
- Death of a Member.

The maximum time frame for reporting an incident shall be 24 hours. The initial report of an incident within 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 48 hours.

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 24 hours a day, 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.

Additional information about fraud, waste, and abuse is available in the Compliance section of this Provider Manual.

Claims for MLTSS Services
Providers are required to bill Molina for all MLTSS waiver services via mail, electronically using EDI submission, or through the Provider Portal. After registering on the Provider Portal, the Provider will be able to check eligibility and claim status and create/submit claims to Molina. To register please visit Provider Portal.

Providers are required to bill Molina for all services.
- Long-term care claims must be billed electronically.
- Waiver-related claims are accepted electronically through the EDI platform, via our Portal, and by mail. Register for the Provider Portal here: Provider Portal.

For information on how to submit a claim via the Provider Portal contact the health plan Provider Network Management team at **(855) 866-5462**.

Electronic Visit Verification (EVV)
The purpose of the Electronic Visit Verification (EVV) system is to facilitate proper reimbursement of individual Providers rendering service to MLTSS enrollees receiving their services.

An in-home service Provider agency must do the following regarding the EVV system:
- Adopt internal policies and procedures.
- Provide training resources and technical support for its employees regarding the proper utilization of its EVV systems.
- Provide help desk or call center access for participants and home care aides regarding the delivery of services.

By nature, the EVV system itself must:
- Enable service Provider agencies to obtain real-time data to arrange regular scheduled visits.
- Enable service Provider agencies to respond in a timely manner to missed visits to ensure reliability in the delivery of care.
- Enable the use of the recorded EVV data for billing, verification, automated billing, and improved administrative efficiencies.

An EVV system must meet the following minimum standards:
- Functional capacity.
- Billing integration and data sharing.
- Data storage and security.
- Electronic reporting interface.
- Disaster recovery.

A system is subject to review and audit by the Illinois Department on Aging: illinois.gov/aging/Pages/default.aspx.

The full administration code can be found on the Illinois General Assembly website: ilga.gov/commission/jcar/admincode/089/089002400O15310R.html.

Billing Molina
For detailed billing information, see the appendices at the end of this section.

All HCBS waiver services, with the exception of personal care workers, are billing to Molina on a professional claim form. A listing of codes, units, services, and taxonomy numbers is at the end of the document. In the absence of a National Provider Identifier (NPI), Providers should bill with their 12-digit HFS Provider ID specifically related to the waiver service. For example, if services are for a Member on the elderly waiver, bill using the HFS Provider number registered for Provider type 090.

Long-term care claims are billed on an 837I and **require** several key data elements, including but not limited to:

- Original admission date.
- Taxonomy codes (provided in the billing guidelines).
- Value code 80 for all covered days.
- Value code 81 for all non-covered days.
- Be mindful of bill type, especially for interim bills.
- All claims are subject to our patient credit file validation process and the application of any Member liability.

Atypical Providers
Atypical Providers are service Providers that do not meet the definition of health care Provider. Examples include Adult Day Care, Respite Care, and Homemaker Services. Although they are not required to register for an NPI, these Providers perform services that are reimbursed by Molina Healthcare of Illinois.

When billing Molina for MLTSS Services as an atypical Provider, refer to the Appendix for more detailed information.

Claims Submission: Online Provider Portal
We encourage our MLTSS Providers to utilize the Provider Portal to submit claims. Please see the Claims and Compensation section of this Provider Manual or the Portal Quick Reference Guide for further details. You may also contact your Provider Network Manager or email the Provider Network Management team at MHILProviderNetworkManagement@MolinaHealthcare.com.

Timely Filing Processing
Standard timely filing is 365 days for the Dual Options Plan.

Timely Claims Processing
Typically, claims are processed within 30 days.

Billing Molina Members
Providers may **not** bill Members. **Balance billing is not allowed.** There is no Member liability, except for Members in a custodial long-term care setting. Members who are living in a long-term care facility, Specialized Mental Health Rehabilitation Facility (SMHRF), Intermediate Care Facility/Mental Illness (ICF/MI), or a Supportive Living

Facility (SLF) may have a cost-share related to their income. The state determines the Member's income and patient liability. That information is shared with Molina via the patient credit file.

For the claim to be considered for payment, the Member must be on the patient credit file for the dates of service, and the Provider billing must also be on the patient credit file. This includes both the LTC Provider and, when applicable, the hospice Provider if the Member is in an LTC facility and receiving hospice services.

Any Member income will be subtracted from the room-and-board charge line and for SLF from the ancillary services (revenue code 0240). For Members living in an LTC facility receiving hospice-related services, the income will be reduced from the room-and-board charges (revenue code 0658).

Provider Claims Dispute (Adjustment Request)
A request to review the processing, payment, or non-payment of a claim by Molina shall be classified as a Provider Claim Dispute and can be submitted through one of the following options:

- Online Provider Portal—Providers are strongly encouraged to use the Portal to submit Provider Claims Disputes.
- Fax—Provider Claims Disputes can be faxed to Molina at **(855) 502-4962**. Must also contain a completed Claims Dispute Form.
- **Note**—CDs containing medical records may be sent to Molina Healthcare of Illinois, Attention: Provider Disputes, 1520 Kensington Rd., Suite 212, Oak Brook IL 60523. Must also include completed Claims Dispute Form.
- **Important**—Please submit only one claim per dispute.

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 Molina first before submitting complaints to the state agency.

Providers have the right to file a complaint if they are dissatisfied with any aspect of operation or service rendered by Molina that does not pertain to a benefit or claim determination. Complaints may be submitted no later than 30 calendar days form the date the Provider becomes aware of the issue generating the complaint.

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

Service	Code	Modifier	Unit/Billing Increment	Taxonomy*
Adult Day Care	S5100		15 minutes	261QA0600X
Adult Day Care Transportation	T2003		1 unit = one-way trip	261QA0600X
Agency Services CNA	T1004		15 minutes	251E00000X 251J00000X
Agency Services – Individualized service provided to more than one patient in the same setting	T1002	TT	15 minutes	251E00000X 251J00000X 282N00000X 253Z00000X
Agency Services – LPN	T1003		15 minutes	251E00000X 251J00000X 282N00000X 253Z00000X
Agency Services – RN	T1002		15 minutes	251E00000X 251J00000X 282N00000X 253Z00000X
Automatic Medication Dispenser	A9901		Per install	332B00000X
Automatic Medication Dispenser – Monthly	T1505		Per month	332B00000X
Behavioral Services – Doctoral Level (PHD)	H0004	HP	Per visit, 1-hour max	251S00000X
Behavioral Services – Master's Degree Level (MA)	H0004	HO	Per visit, 2-hour max	251S00000X
Home-Delivered Meals	S5170		2 meals = 1 unit Max = 1 unit per day	332U00000X
Home Modification	S5165		Varies with services, max $25,000.00 in a five-year period	171WH0202X 171W00000X
Homemaker	S5130		15 minutes	376J00000X 251E00000X
Occupational Therapy	G0152		15 minutes, max = 4 hours per day	225X00000X 251E00000X
Personal Emergency Response – Install	S5160		Per install	146D00000X 3333300000X
Personal Emergency Response –Monthly	S5161*	**	Per month	146D00000X 333300000X
Physical Therapy	G0151		15 minutes, max = 4 hours per day	225100000X 251E00000X
Prevocational Services	T2014		Per diem	251S00000X 251E00000X
Respite Adult Day Care	T1005	HQ	15 minutes	261QA0600X 385H00000X
Respite Adult Day Care – Transportation	T1005	HB	1 unit = 1 trip Max = 2 daily	261QA0600X 385H00000X
Respite Agency Services Home Health Aide (CNA)	T1005	SC	15 minutes	385H00000X 376J00000X 251E00000X
Respite Agency Services – LPN	T1005	TE	15 minutes	385H00000X 376J00000X 251E00000X

Service	Code	Modifier	Unit/Billing Increment	Taxonomy*
Respite Agency Services – RN	T1005	TD	15 minutes	385H00000X 376J00000X 251E00000X
Respite Homemaker	T1005	SE	15 minutes	385H00000X 376J00000X
Specialized Medical Equipment/Supplies – Purchase	T2028		Per service	332B00000X
Specialized Medical Equipment/Supplies – Rental	T2028	RR	Per service, max $1,225 per month	332B00000X
Speech Therapy	G0153		Per visit, 4 hours max	235Z00000X 251E00000X
Speech Therapy – Services Delivered Under an Outpatient Hospital Speech Language Pathology Plan of Care	G0153	GN	Per visit	235Z00000X 282N00000X
Supported Employment No Job Coach Individual	T2019		1 unit = 1 hour	251S00000X 261QR0400X 251E00000X
TBI Day Habilitation	T2020		Per diem	261QR0400X 373H00000X 251E00000X

* Other taxonomy numbers may be accepted. However, these are the recommended codes for Molina.

** Exception for Molina: When services are provided on a cellular platform vs. a landline, S5161 should include the U2 modifier.

Appendix 2: Nursing Facility Billing Guidance

Nursing Facility claims can only be submitted via the 837I (electronic/EDI submission). The Nursing Facility Billing Guidance for Illinois are listed below.

Bill Type FL 04	Bill Type Description	Inpatient or Outpatient	Legacy Cos	Legacy Cos Description	Revenue Code FL 42	Revenue Code Description	Occurrence Code FL 31-34	Occurrence Span Code FL 35-36	Value Code FL 39-41	Value Code Description
Provider Type 028 Alzheimer/Dementia Center Taxonomy Code: 311500000X										
089X	Special Facility - Other	OP	86	LTC SLF Dementia Care	0240	All Inclusive Ancillary/General		N/A	80	Covered Days
089X	Special Facility - Other	OP	86	LTC SLF Dementia Care	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
Provider Type 028 Assisted Living Facility Taxonomy Code: 310400000X										
089X	Special Facility - Other	OP	87	LTC - Supportive Living Facility (Waivers)	0240	All Inclusive Ancillary/General		N/A	80	Covered Days
089X	Special Facility - Other	OP	87	LTC - Supportive Living Facility (Waivers)	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
Provider Type 033 Skilled Nursing Facility Taxonomy Code: 314000000X										
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	70	LTC - Skilled	0110 - 0160*	General Room & Board Values	***If Recipient Has Medicare Part A*** A2 - Eff. Date of Medicaid A3 - Benefits Exhausted B3 - Benefits Exhausted - Payer B 22 - Date Active Care Ended 25 - Date Benefits Terminated	N/A	80	Covered Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	70	LTC - Skilled	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered

Provider Type 033 Skilled Nursing Facility Taxonomy Code: 314000000X										
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	**65	LTC Full Medicare Coverage	0110 - 0160*	General Room & Board Values		70	80	Covered Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	**72	LTC-NF Skilled-Co-Ins (partial Medicare coverage)	0110 - 0160*	General Room & Board Values		70	82	Co Ins. Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	38	Exceptional Care - TBI Level I Exceptional Care - TBI Level II Exceptional Care - TBI Level III Exceptional Care - VENT	0191 0192 0193 0194	Subacute Care - Level I Subacute Care - Level II Subacute Care - Level III Subacute Care - Level IV		N/A	80	Covered Days
079X	Clinic-Other	OP	083	Developmental Training	0942	Education/Training				
Provider Type 033 Nursing Facility / Intermediate Care Facility Taxonomy Code: 314000000x										
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
079X	Clinic-Other	OP	083	Developmental Training	0942	Education/ Training		N/A		
Provider Type 033 General Acute Care Hospital (LTC wing) Taxonomy Code: 282N00000X										
011X 021X	Hospital Inpatient (Including Medicare Part A) Skilled Nursing Inpatient (Including Medicare Part A)	IP	70	LTC - Skilled	0110 - 0160*	General Room & Board Values	***If Recipient Has Medicare Part A*** A2 - Eff. Date of Medicaid A3 - Benefits Exhausted B3 - Benefits Exhausted - Payer B 22 - Date Active Care Ended 25 - Date Benefits Terminated	N/A	80	Covered Days
011X 021X	Hospital Inpatient (Including Medicare Part A) Skilled Nursing Inpatient (Including Medicare Part A)	IP	70	LTC - Skilled	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered

Provider Type 033 General Acute Care Hospital (LTC wing) Taxonomy Code: 282N00000X										
021X	Skilled Nursing Inpatient (Including Medicare Part A)	IP	**65	LTC Full Medicare Coverage	0110 - 0160*	General Room & Board Values		70	80	Covered Days
021X	Skilled Nursing Inpatient (Including Medicare Part A)	IP	**72	LTC-NF Skilled-Co-Ins (partial Medicare coverage)	0110 - 0160*	General Room & Board Values		70	82	Co Ins. Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	38	Exceptional Care - TBI Level I Exceptional Care - TBI Level II Exceptional Care - TBI Level III Exceptional Care - VENT	0191 0192 0193 0194	Subacute Care - Level I Subacute Care - Level II Subacute Care - Level III Subacute Care - Level IV		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
079X	Clinic-Other	OP	083	Developmental Training	0942	Education/ Training		N/A		
Provider Type 038 Intermediate Care Facility, Mental Illness Taxonomy Code: 310500000X										
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
					* Except for 0115, 0125, 0135, 0145 or 0155		1.			

Notes: ** When billing Medicare Covered services directly claim must include the Other Payer Loop showing the Medicare TPL code 909 and the Medicare adjudication information
The Occurrence Span Code (70) showing the Qualifying Stay is not required by HFS but can be reported on direct billed claims for Medicare Covered services
If Recipient Has Medicare Part A and Medicaid covered services are being billed an Occurrence Code showing Medicare benefit end date or Medicaid coverage begin date must be included on the claim

6. Quality

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 **(855) 866-5462** or fax **(855) 556-2074**.

Mail requests:

Molina Healthcare of Illinois, Inc.
Quality Department
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

This Provider Manual contains excerpts from the Molina Quality Improvement Program. For a complete copy of Molina's Quality Improvement Program, contact your Provider Network Manager or call the telephone number above to receive a written copy.

Molina has established a Quality Improvement Program that complies with regulatory requirements and accreditation standards. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service, and health of our Members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure, and responsibilities.

Molina does not delegate quality improvement activities to medical groups/IPAs. However, Molina requires contracted medical groups/IPAs to comply with the following core elements and standards of care. Medical groups/IPAs must:

- 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.
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services, as well as Member experience.
- Allow Molina to collect, use, and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas (such as clinical care), care coordination and management, service, and access and availability.
- 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 Care 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 established a systematic process to identify, investigate, review, and report any 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 is 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 medical record components, that include but are not limited to:

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

Medical Record-Keeping Practices
Below is a list of the minimum items that are necessary in the maintenance of the Molina 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 24 hours.
- If hard copy, 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 HIPAA compliance.

- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving medical records and implementing improvement activities.
- Medical records are kept confidential, and there is a process for release of medical records including behavioral health care records.

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

- Each page in the record contains the patient's name or Molina ID number.
- 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.
- Weight and height information and, as appropriate, growth charts.
- 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.
- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that Advance 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 Provider.
- 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.
- Family planning and counseling, obstetrical history, and profile.
- 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 Illinois Department of Healthcare and Family Services and the external quality review organization upon request.
- The medical record is available to the Member upon his/her request.
- A storage system for inactive Member medical records that allows retrieval within 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 year past his/her 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 (PHI) in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include, and is not limited to, the following:
- Ensure that medical information is released only in accordance with applicable federal or state law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health 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. For additional information regarding HIPAA, see the Compliance Section of this Provider Manual.

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 PCPs (adult and pediatric) and participating specialists (to include OB-GYN, behavioral health Providers, and high-volume and high-impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 90% availability for Emergency Services and 90% or greater for all other services. The PCP or his/her designee must be available 24 hours a day, 7 days a week to Members.

Appointment Access
All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the time frames noted:

Medical Appointment Types	Standard
Routine Preventive Care	Within 5 weeks from the date of request
Routine Preventive Care for Infant	Within 2 weeks from the date of request
Routine, Symptomatic, but Not Deemed Serious	Within 3 weeks from the date of request
Urgent Care	Within 24 hours
After-Hours Care	24 hours/day 7 days/week availability
Specialty Care (High Volume)	Within 3 weeks from the date of request (for complaints not deemed serious)
Specialty Care (High Impact)	Within 3 weeks from the date of request (for complaints not deemed serious)
Urgent Specialty Care	Within 24 hours
Initial Prenatal Visit—First Trimester	Within 2 weeks from the date of request
Initial Prenatal Visit—Second Trimester	Within 1 week from the date of request
Initial Prenatal Visit—Third Trimester	Within 3 days from the date of request

Behavioral Health Appointment Types	Standard
Life-Threatening Emergency	Immediately
Non-Life-Threatening Emergency	Within 6 hours
Urgent Care	Within 48 hours
Initial Routine Care Visit	Within 10 business days
Follow-Up Routine Care Visit	Within 30 calendar days

Additional information on appointment access standards is available from your local Molina Quality department.

Office Wait Time
For scheduled appointments, the wait time in offices until seen by the PCP should not exceed 60 minutes from appointment time. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours
All Providers must have back-up (on call) coverage after hours, or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service seven days per week. The Provider must have a published after-hours telephone number. This access may be through an answering service or other arrangements. Voicemail alone after hours is not acceptable.

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 Molinahealthcare.com website or from your local Molina Quality department.

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 one or more of the following mechanisms:
1. Provider access studies—Provider office assessment of appointment availability, after-hours access, Provider ratios, and geographic access.
2. Member complaint data—Assessment of Member complaints related to access and availability of 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 and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Quality of Provider Office Sites
Molina Providers are to maintain office-site and medical record-keeping practices standards. Molina continually monitors Member complaints and appeals/grievances for all office sites to determine the need for an office site visit and will conduct office site visits as needed. 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 includes an assessment of:

- Physical Accessibility.
- Physical Appearance.
- Adequacy of Waiting and Examining Room Space.

Physical Accessibility
Molina evaluates office sites, as applicable, 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 patients with physical disabilities.

Physical Appearance
The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of Waiting and Examining Room Space
During the site visit, as required, 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.

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.
- Accessible 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, bloodborne 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 are restricted.
- A system is 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.

Advance Directives (Patient Self-Determination Act)
Molina complies with the Advance Directive requirements of the states in which the organization provides services. Responsibilities include ensuring Members receive information regarding Advance Directives and that contracted Providers and facilities uphold executed documents**.**

Advance Directives are a written choice for health care. Illinois has four types of Advance Directives:
- **Health Care Power of Attorney**—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.
- **Do-Not-Resuscitate Order (DNR)**—A medical order stating that cardiopulmonary resuscitation cannot be performed if the heart or breathing stops.
- **Mental Health Treatment Preference Declaration**—Allows the Member to state whether they want to receive electroconvulsive treatment or psychotropic medicine.

When There Are No Advance Directives
The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult Molina Members 18 years of age 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 Directive 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 CaringInfo website at 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 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's 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 Directive 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 Directives 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.

EPSDT Services to Enrollees Under 21 Years of Age
Molina maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services to Enrollees under 21 years of age are timely according to required preventive guidelines. All Enrollees under 21 years of age should receive preventive, diagnostic, and treatment services at intervals as set forth in Section 1905(R) of the Social Security Act. Molina's Quality or the Provider Network Management department is also available to perform Provider training to ensure that best-practice guidelines are followed in relation to well-child services and care for acute and chronic health care needs.

Well Child/Adolescent Visits
Visits consist of age-appropriate components that include but are not limited to:
- Comprehensive health and developmental history.
- Nutritional assessment.
- Height, weight, and growth charting.

- Comprehensive unclothed physical examination.
- Appropriate immunizations according to the Advisory Committee on Immunization Practices.
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool.
- Vision and hearing tests.
- Dental assessment and services.
- Health education, including anticipatory guidance such as child development, healthy lifestyles, and accident and disease prevention.

Diagnostic services, treatment, or services Medically Necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

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

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

Quality Improvement Activities and Programs
Molina maintains an active Quality Improvement Program. The Quality Improvement Program 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 and Care Management
The Molina Health Management and Care Management Programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases. For additional information, please see the Health Management and Care Management headings in the Health Care Services section of this Provider Manual.

Clinical Practice Guidelines
Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature, and/or appropriately established authority. Clinical Practice Guidelines are reviewed at least annually and more frequently as needed, when clinical evidence changes and is approved by the Quality Improvement Committee.

Molina Clinical Practice Guidelines include the following:
- Acute Stress and Post-Traumatic Stress Disorder (PTSD).
- Adult Preventive Care.
- Anxiety/Panic Disorder.
- Asthma.
- Attention Deficit Hyperactivity Disorder (ADHD).
- Bipolar Disorder.
- Chronic Kidney Disease.
- Chronic Obstructive Pulmonary Disease (COPD).
- Clinical Pharmacy Medication Review.
- Community Reintegration and Support.
- Congestive Heart Failure (CHF).
- Coordination of Community Support and Services for Enrollees In HCBS Waivers.
- Coronary Artery Disease (CAD).
- Dental Services.
- Depression.
- Detoxification and Substance Abuse Treatment.
- Diabetes.
- Heart Failure.
- Hypertension.
- Long-Term Care (LTC) Residential Coordination of Services.
- Mental Health.
- Obesity.
- Opioid Management.
- Perinatal/Prenatal/Postnatal Care.
- Pharmacy Services.
- Prenatal, Obstetrical, Postpartum, and Reproductive Health Care.
- Psychotropic Medication Management.
- Sickle Cell Disease.
- Smoking Cessation.

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates, and Members by the Quality, Provider Network Management, Health Education, and Member Services departments. The guidelines are disseminated through Provider newsletters, electronic Provider bulletins, and other media and are available on the Molina website. Individual Providers or Members may request copies from the Molina Quality department.

Preventive Health Guidelines
Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics, and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Care for children up to 24 months old.
- Care for children two to 19 years of age.
- Care for adults 20 to 64 years of age.
- Care for adults 65 years and older.
- Immunization schedules for children and adolescents.
- Immunization schedules for adults.

All guidelines are updated at least annually and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to Providers at 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 programs 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®).
- Behavioral Health Survey.
- 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 their 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 the Molina Quality team by visiting our website at 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. The results 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 their Providers, and 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 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.

Behavioral Health Survey
Molina obtains feedback from Members about their experience, needs, and perceptions of accessing behavioral health care. This feedback is collected at least annually to understand how our Members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan, and perceived improvement in their conditions, among other areas.

Medicare Health Outcomes Survey (HOS)
The HOS measures Medicare Members' physical and mental health status over a two-year period and categorizes the two-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®/Qualified Health Plan Enrollee Experience Survey 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.

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 patient's age and/or condition has been missed.
- Check that staff is properly coding all services that were provided.
- 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 visit the Provider Portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Molina Quality department.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

Merit-Based Incentive Payment System (MIPS)
Under the Medicare Access and CHIP Reauthorization Act (MACRA), CMS implemented the Quality Payment Program Merit-based Incentive Payment System (MIPS). This is a Quality Payment Program that eligible Providers under original Medicare will participate in and does not impact how Medicare Advantage and MMP plans are required to pay. Due to this being a quality program, Providers will not receive a bonus or a withhold for the Quality Payment Program Merit-based Incentive Payment

System (MIPS), unless it is specifically in the agreement you have with Molina. Please contact your Provider Network Manager for other quality programs Molina offers.

7. Risk Adjustment Management Program

The Centers for Medicare & Medicaid Services (CMS) defines Risk Adjustment as a process that helps accurately measure the health status of a plan's Membership based on medical conditions and demographic information.

This process helps ensure that health plans receive accurate payment for services provided to Molina Members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

Why is Risk Adjustment Important?
Molina relies on our Provider Network to take care of our Members based on their health care needs. Risk Adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identify opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality and efficiency.
- Recognize and address current and potential health conditions early.
- Identify Members for Care Management referral.
- Ensure adequate resources for the acuity levels of Molina Members.
- Have the resources to deliver the highest quality of care to Molina Members.

Your Role as a Provider
As a Provider, your complete and accurate documentation in a Member's medical record and submitted claims are critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest specificity, as this will ensure Molina receives adequate resources to provide quality programs to you and our Members.

To constitute a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the Member.
- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a face-to-face visit with the Member.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Include the Provider's signature and credentials.

RADV Audits
As part of the regulatory process, state and/or federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Molina is appropriate and accurate. All claims/encounters submitted to Molina are subject to state and/or federal and internal health plan auditing. If Molina is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Contact Information
For questions about Molina's Risk Adjustment Programs, please contact our team at: RiskAdjustment.Programs@MolinaHealthcare.com.

8. 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 U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guides 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 (LEP) 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, genders, gender identities, sexual orientations, ages, 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 MolinaHealthcare.com, from your Provider Network Manager, or by calling Molina's Provider Network Management department at **(855) 866-5462**.

Nondiscrimination of Health Care 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 homepages.

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, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Providers must post a nondiscrimination notification in a conspicuous location in their office along with translated non-English taglines in the top 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/Independent Practice Associations (IPAs) may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

Providers can refer Molina Members who are complaining of discrimination to the Molina Civil Rights Coordinator at **(866) 606-3889** (TTY, 711).

Members can email the complaint to civil.rights@MolinaHealthcare.com.

Members can mail their complaint to Molina:

Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Members can also file a civil rights complaint with the U.S. Department of Health and Human Services (HHS), OCR. Complaint forms are available at hhs.gov/ocr/complaints/index.html. The form can be mailed to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

Members can also send it to a website through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you or a Molina Member need help, call **(800) 368-1019** or TTY **(800) 537-7697**.

Should you or a Molina Member need more information, refer to the Health and Human Services website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Cultural Competency

Molina is committed to reducing health care disparities. Training employees, Providers, and their staff, and monitoring quality 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 enhances 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 Network Management and/or online/web-based training modules.

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

1. Provider written communication and resource materials.
2. On-site cultural competency training.
3. Online cultural competency Provider training modules.

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 interpretation, American Sign Language (ASL), and written translation. Molina must also ensure access to programs, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with LEP.

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

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

Program and Policy Review Guidelines
Molina conducts assessments of the following information at regular intervals 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 a plan's Membership.
  - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (community health measures and state rankings report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

Access to Interpreter Services
Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at **(877) 901-8181**. 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 notification of his/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 the Member and Provider Contact Center, Quality, Health Care Services, and all other health plan functions.

Molina strongly recommends that Provider offices make assistive listening devices available for Members who are deaf or 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 business 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 Nurse Advice Services for Members 24 hours per day, 7 days per week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly: English **(888) 275-8750** or TTY **(888) 735-2929**, Spanish **(866) 648-3537** or TTY **(866) 833-4703**. The Nurse Advice Line telephone numbers are also printed on Membership cards.

9. 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 that addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste, and abuse prevention and detection, along with 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.
- 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.

As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of funds either by fraud, waste, or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

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

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

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

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

Affected entities who fail to comply with the law will be at risk of forfeiting all 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 services **provided only by practitioners**, rather than by all health care Providers.

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—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 state and federal health care programs.

Abuse—Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the state and federal health care programs or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the state and federal health care 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:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship (Stark Law).
- Altering claims and/or medical record documentation 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 for and providing 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 to receive or maximize reimbursement.
- Inappropriate billing of modifiers to receive or maximize reimbursement.
- Inappropriate billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization.
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.

- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like service 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:
- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud state and federal health care programs.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation 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 they do 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 that 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.

Molina has a prepayment claims auditing process that identifies frequent correct coding billing errors, ensuring that claims are coded appropriately according to state and federal coding guidelines. Code edit relationships and edits are based on guidelines from specific state Medicaid Guidelines, Centers for Medicare & Medicaid Services

(CMS), federal CMS guidelines, AMA, and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), and state-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Molina may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews, whereupon the Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the claim will be denied until such time that the Provider can provide sufficient accurate support.

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, at 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, and 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 are 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 (CAP) 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 reporting is available 24 hours per day, 7 days per week, 365 days per 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 before submitting 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 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 Illinois, Inc.
Attn: Compliance
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523
Telephone: (888) 858-2156
Fax: (630) 571-1220

Include the following information when reporting:
- Nature of complaint.
- The names of individuals and/or entities involved in suspected fraud and/or abuse, including address, phone number, Molina Member ID number, and any other identifying information.

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

Illinois State Police
Medicaid Fraud Control Unit
8151 W. 183rd Street, Suite F
Tinley Park, Illinois 60477
Toll Free Phone: (844) 453-7283/ (844) ILFRAUD

Illinois Attorney General

Online at: illinois.gov/hfs/oig/Pages/ReportFraud.aspx

HIPAA Requirements and Information

HIPAA (Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all federal and state laws regarding the privacy and security of Members' Protected Health Information (PHI).

Provider Responsibilities

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

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:

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 Disclosure 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 health care Treatment, Payment, and Operations (TPO) activities 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 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 that 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.

[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

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 or 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.

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-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 cybersecurity 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 strongly supports the use of electronic transactions to streamline health care admin activities. Providers are encouraged to submit claims and other transactions to Molina using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule, including but not limited to the following:

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

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at 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 (NPI)
Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina within 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.

10. Health Care Services (HCS)

Introduction
Health Care Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated 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. Molina provides Care Management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina Utilization Management Program include pre-service authorization request/organization determination and inpatient authorization management that includes pre-admission, admission, and concurrent review, Medical Necessity review, and restrictions on the use of out-of-network Providers.

Utilization Management (UM)
Molina ensures the service delivered is Medically Necessary and demonstrates an appropriate use of resources based on the level 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, as well as integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes in the Member's condition and is designed to influence Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care is provided.
- Evaluating the Medical Necessity and efficiency of 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.
- 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 and CM processes.
- Ensuring that UM decision-making tools are appropriately applied in determining Medical Necessity decisions.

Key Functions of the UM Program
The following table 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 Provider input
Benefit administration and interpretation	Pre-admission, Admission, and Inpatient Review	Utilization data analysis
Ensure authorized care correlates to Member's Medical Necessity need(s) & benefit plan	Post service/post claim audits	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

This Molina Provider Manual contains excerpts from Molina's Health Care Services Program description. For a complete copy of the state's Health Care Services Program description, access the Molina website or contact the UM department to receive a written copy. You can always find more information about Molina's UM Program—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.

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. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina uses CMS guidelines, state guidelines, nationally recognized evidence-based guidelines, third-party guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

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 Care Manager criteria reviews as meeting the clinical information requirements unless state or federal regulations allow 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 normally updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at MolinaHealthcare.com.

Requests for Prior Authorization may be sent by telephone, fax, mail, or via the Provider Portal.

Providers are encouraged to use the Molina Prior Authorization form provided on the Molina website. If using a different form, the Prior Authorization request **must** include the following information:

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information that is sufficient to document the Medical Necessity of the requested service including:
    - Pertinent medical history (include treatment, diagnostic tests, examination data).
    - Requested length of stay (for inpatient requests).
    - Rationale for expedited 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 Medical Necessity and 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. 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, health or safety of the Member or others due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Enrollee's medical or behavioral health condition would subject the Member to adverse health consequences without the care or treatment that is subject of the requestor, or could jeopardize the Enrollee's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited organization determination/pre-service request, we make a determination as promptly as the Member's health requires and no later than 48 hours after we receive the initial request for service in the event a Provider indicates, or if we determine that a standard authorization decision time frame could jeopardize a Member's life or health. For a standard authorization request, Molina makes the determination and provides notification within four 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 (peer-to-peer call) with the requesting Provider by contacting the nurse reviewer by telephone as indicated on the denial notification. Providers can also submit a request for "reconsideration" in place of a peer-to-peer call if significant information was left out of the original request.

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 organization determinations/pre-service authorization requests and will allow a peer-to-peer conversation in limited circumstances:

- While the request is being reviewed, but prior to a final determination being rendered.
- While an appeal of an organization determination/pre-service authorization request 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 time frames 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 Molina 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), Molina 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 you that you must follow the rules for requesting a Medicare appeal. Refer to the Member Grievances and Appeals section of this Provider Manual.

Requesting Prior Authorization
Notwithstanding any provision in the Provider Agreement that requires Provider to obtain a Prior Authorization directly from Molina, Molina may choose to contract with external vendors to help manage Prior Authorization requests.

For additional information regarding the Prior Authorization of specialized clinical services, refer to the Prior Authorization tools on the MolinaHealthcare.com website:
- Prior Authorization Code Lookup Tool.
- Prior Authorization Code Matrix.
- Prior Authorization Guide.

The most current Prior Authorization guidelines and the Prior Authorization Request Form can be found on the Molina website at MolinaHealthcare.com.

Provider Portal
Participating Providers are encouraged to use the Provider Portal for Prior Authorization submissions whenever possible. Instructions for how to submit a Prior Authorization request are available on the Provider Portal. The benefits of submitting your Prior Authorization request through the Portal are:
- Create and submit Prior Authorization requests.
- Check status of Prior Authorization requests.
- Receive notification of change in status of Prior Authorization requests.
- Attach medical documentation required for timely medical review and decision-making.

Fax: The Prior Authorization Request Form can be faxed to Molina at **(866) 617-4971**.

Phone: Prior Authorizations can be initiated by contacting Molina's Health Care Services department at **(855) 866-5462**. It may be necessary to submit additional documentation before the authorization can be processed.

Molina has different fax numbers for preauthorization requests for the following specialized clinical services:
- Imaging and special tests:
  - Advanced imaging (MRI, CT, PET, selected ultrasounds).
  - Cardiac imaging.
- Radiation therapy.
- Sleep covered services and related equipment.
- Molecular and genomic testing.

Imaging and special tests: **fax (877) 731-7218**. Radiation and specialized services: **fax (844) 251-1451**. Please refer to the Molina Prior Authorization Code Matrix located on the Frequently Used Forms page of the MolinaHealthcare.com website under Authorization Requests.

Affirmative Statement About Incentives
All medical decisions are coordinated and rendered by qualified physicians and licensed clinical staff, unhindered by fiscal or administrative concerns. Molina and its delegated

contractors do **not** use incentive arrangements to reward the restriction of medical care to Members.

Molina requires that all utilization-related decisions regarding Member coverage and/or services are based solely on appropriateness of care and service and existence of coverage. Molina does not specifically reward practitioners or other individuals for issuing denials of coverage or care, and Molina does not receive financial incentives or other types of compensation 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, and other coverage arrangements.

Clinical Trials
For information on clinical trials, go to 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
Molina may delegate UM functions to qualifying medical groups/IPAs and delegated entities. They must have the ability to meet, perform the delegated activities, and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Communication and Availability to Members and Providers
During business hours, HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff at **(855) 866-5462** Monday through Friday (except for holidays) from 8 a.m. to 5 p.m., Central Time. 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.

After business hours, Providers can also utilize fax and the Provider Portal for UM access.

Molina's Nurse Advice Line is available to Members and Providers 24 hours per day, 7 days per week at **(888) 275-8750**. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. PCPs are notified via fax of all Nurse Advice Line encounters.

Levels of Administrative and Clinical Review
The Molina review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage. Clinical review includes Medical Necessity and level of care.

All UM requests that may lead to a denial are reviewed by a health care professional at Molina (Medical Director, Pharmacy Director, or appropriately licensed health professional).

Molina's Provider training includes information on the UM processes and authorization requirements.

Emergency Services
Emergency Services are covered inpatient and outpatient health care 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 overutilizing the Emergency Department will be contacted by Molina Care Managers to provide assistance whenever possible and determine the reason for using Emergency Services.

Care 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.

Inpatient Management
Elective Inpatient Admissions
Molina requires Prior Authorization for all elective/scheduled inpatient procedures and admissions to any facility. Facilities are required to also notify Molina within 24 hours or by the following business day once the admission has occurred for concurrent review. 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 24 hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care, and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission, and clinical information sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting notification, Medical Necessity requirements, or failure to include all of the needed clinical documentation to support the inpatient admission, will result in a denial of authorization for the inpatient stay.

Post-service Medical Necessity review is performed when:

- Information is received indicating the Provider did not know, or reasonably could not have known, that the patient was a Molina Member.
- There was a Molina clerical error.

Inpatient at Time of Termination of Coverage

If a Member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility for a hospital with a per diem contract will **not** be covered services. For those Members whose coverage with Molina terminates while at a Diagnosis-Related Group (DRG) hospital, services are generally covered until date of discharge from that hospital.

Prospective/Pre-Service Review

Pre-service review defines the process, qualified personnel, and time frames 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.
- The PCP is kept apprised of service requests and of the service provided to the Member by other Providers.

Inpatient/Concurrent Review
Molina performs concurrent inpatient review to ensure 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.
- Member who is appropriate for outpatient care management is identified and referred.

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

NOTICE Act
Under the NOTICE Act, hospitals and Critical Access Hospitals (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 24 hours. See the final rule that went on display August 2, 2016 (published August 22, 2016) at Federalregister.gov/documents.

Inpatient Status Determinations
Molina's UM staff determines 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), 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 Health Care Services section of this Provider Manual.

Discharge Planning

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. UM staff works closely with the hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff reviews Medical Necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), Skilled Nursing Facility, and rehabilitative services.

Readmissions

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 participating hospitals when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates. There are two situations for readmissions: Readmissions occurring within 24 hours from discharge (same or similar diagnosis), and readmissions occurring within 2–30 days of discharge (same or similar diagnosis **plus** preventable).

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 2–30 days of discharge, and it is determined that the readmission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

A readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:

- Premature or inadequate discharge from the same hospital.
- Issues with transition or coordination of care from the initial admission.
- For an acute medical complication plausibly related to care that occurred during the initial admission.

Readmissions that are excluded from consideration as preventable readmissions include:

- Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
- Neonatal and obstetrical readmissions.
- Transplant-related admissions.
- Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed.

Readmissions for Substance Use Detoxification and Withdrawal

Molina will conduct readmission reviews for all in-state hospitals when the patient has been admitted twice within 60 days at any hospital (does not need to be the same

hospital). Readmission within 60 days for detoxification or withdrawal is **not** covered, per state regulation. See Public Act 097-0689, otherwise known as the SMART Act, for details: illinois.gov/hfs/MedicalProviders/notices/Pages/prn120630f.aspx. The state's intent with this act was to ensure appropriate and close follow-up for patients with substance use disorder.

Post-Service Review
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 or state requirements or Provider contracts that prohibit administrative denials supersede this policy.

Out-of-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 to 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 authorized by Molina. Non-network Providers may provide Emergency Services 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 that 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 underutilization. Molina also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care and Services
Molina HCS staff members work with Providers to assist with coordinating referrals, services, and benefits for Members who have been identified for Molina's Integrated Care Management (ICM) Program via assessment, or referral such as self-referral, Provider referral, etc. 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 need continued care.

Molina staff members provide an integrated approach to care needs by assisting Members with identification of resources available to Members, such as community programs, national support groups, appropriate specialists and facilities, dental and vision services, as well as identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members, and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

There are three main coordination of care processes for Molina Members.

- The first occurs when a new Member enrolls in Molina and needs to transition current medical care to Molina-contracted Providers. Mechanisms within the enrollment process identify these Members, and the Member & Provider Contact Center (M&PCC) reaches out to the Members to assist in obtaining authorizations, transferring to contracted Durable Medical Equipment (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 transitioning to other care. The process includes mechanisms for identifying Molina Members whose benefits are ending and need continued care.
- The third is the care management of Members who request care coordination, those whose Provider(s) request care coordination for them, and Members identified by Molina due to risk categories as a result of either acute or chronic conditions, high utilization, or a combination of risk factors. Molina seeks agreement of those Members to enter into care coordination. Through the course of engagement with the Care Manager, the Member, care coordinator, and the Member's Integrated Care Team (ICT)—which may include the Provider(s)—develop an Individualized Care Plan (ICP) with goals to address the Member's main health concerns.

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

- Notification of community resources, and local or state-funded agencies.
- Education about alternative care.
- 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; a Provider that has terminated its

contractual agreement can provide continued services to Members undergoing a course of treatment 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 for up to 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 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 **(855) 866-5462**.

Continuity and Coordination of Provider Communication
Molina stresses the importance of timely communication between all Providers involved in a Member's care. This is especially critical between specialists, including Behavioral Health (BH) Providers and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

UM Decisions
A decision is any determination (e.g., an approval or denial) made by Molina or 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.
- 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.

Molina follows a hierarchy of Medical Necessity decision-making, with federal and state regulations taking precedence. Molina covers all services and items required by state and federal regulations.

Board-certified, licensed Providers from appropriate specialty areas are 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 and state regulatory requirements and NCQA standards.

Requests for authorization not meeting criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, 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.

Providers can contact Molina's Health Care Services department at **(855) 866-5462** to obtain Molina's UM criteria.

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.

1. **Initial organization determinations/pre-service authorization requests**—A request for expedited determinations may be made. A request is expedited if applying the standard determination time frames could seriously jeopardize the life or health of the Member or the Member's ability to regain 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 requests must be made as soon as Medically Necessary, within 72 hours (including weekends and holidays) following receipt of the validated request.
   - Standard requests must be made as soon as medically indicated, within a maximum of 14 calendar days after receipt of the request.

   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.

2. **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 notice 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, time frames, 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, time frames, and other elements of the appeal process.

- 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.

3. **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), coverage of Home Health Agencies (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services occurs, the Member must receive a written notice two calendar days or two 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. All elements of the NOMNC are required, and the Member or authorized representative must sign and date the notice to document receipt.
   - The NOMNC must include the Member's name, delivery date, date that coverage of services ends, and Quality Improvement Organization (QIO) information.
   - The NOMNC may be delivered earlier than two days before coverage ends.
   - If coverage is expected to be fewer than two days in duration, the NOMNC must be provided at the time of admission.
   - If home health services are provided for a period of time exceeding two 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 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, a delivery of the notice is not valid unless appealed. 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.
   - 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 receiving or may be in need of receiving 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/herself or unable to protect him/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 **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 childcare givers.
- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers.

If you believe anyone is in immediate danger, **call 911 first**. All critical incidents and cases of suspected abuse and/or neglect should be reported to the Molina Quality team:

Phone: (855) 866-5462
Fax: (855) 556-2074
Email: MHIL-QI@molinahealthcare.com

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

Child Abuse
Call the 24-hour Child Abuse Hotline at **(800) 25-ABUSE**, **(800) 252-2873**, or **TTY (800) 358-5117** if you suspect that a Member under the age of 18 has been harmed or is at risk of being harmed by abuse or neglect. If you believe a child is in immediate danger of harm, **call 911 first**.

For Members 18 to 59 years of age receiving mental health or developmental disability services in a DHS operated, licensed, certified, or funded programs, report incidents to the Department of Human Services (DHS) Office of the Inspector General (OIG) 24-hour hotline at **(800) 368-1463** (voice and TTY).

Adult Abuse
To report suspected abuse, neglect, or financial exploitation of an adult age 18 or older or a person with disabilities 18 to 59 years of age, call the statewide, 24-hour Adult Protective Services Hotline at **(866) 800-1409** or **TTY (800) 206-1327.**

For residents who live in nursing facilities, call the Illinois Department of Public Health's Ombudsman Hotline at **(844) 528-8444**.

For Members aged 18 to 59 receiving mental health or developmental disability services in DHS-operated, licensed, certified, or funded programs, call the DHS Office of the Inspector General Hotline at **(800) 368-1463** (voice and TTY).

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 Health Care Services 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 24-hour basis without the need for Prior Authorization for all Members experiencing an emergency medical condition.

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

For Members within our service area: Molina contracts with vendors that provide 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.
- 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-service request within one 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 provide 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 Molina. Urgent Services are covered services that are Medically Necessary and are needed urgently, typically the same day or within two 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's health specialists for routine and preventive health without a referral for 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.

Care Management (CM)
The Integrated Care Management (ICM) 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. Care Management focuses on the delivery of quality, cost-effective, and appropriate health care services for Members who have been identified for Molina's ICM Program. Members may receive health risk assessments that help identify physical health, behavioral health, medication management problems, and Social Determinants of Health (SDOH) to target high-needs Members who would benefit from assistance and education from a Care Manager. Additionally, functional, social support and health literacy deficits are assessed, as well

as safety concerns and caregiver needs. To initiate the Care Management process, the Member is screened for appropriateness using specified criteria.

The role of the Care Manager includes:
- Coordination of quality and cost-effective services.
- Appropriate application of benefits.
- Promotion of early, intensive interventions in the least restrictive setting of the Member's choice.
- Assistance with transitions between care settings and/or Providers.
- Provision of accurate and up-to-date information to Providers regarding completed health assessments and care plans.
- Creation of ICPs, updated as the Member's condition, needs, and/or health status change.
- Facilitation of Interdisciplinary Care Team (ICT) meetings as needed.
- Promotion of utilization of multidisciplinary clinical, behavioral, and rehabilitative services.
- Referral to and coordination of appropriate resources and support services, including but not limited to Managed Long-Term Services & Supports (MLTSS).
- Attention to Member preference and satisfaction.
- Attention to the handling of Protected Health Information (PHI) and maintaining confidentiality.
- Provision of ongoing analysis and evaluation of the Member's progress toward ICP adherence.
- Protection of Member rights.
- Promotion of Member responsibility and self-management

Referral to Care Management may be made by any of the following entities:
- Member or Member's designated representative(s).
- Member's Primary Care Provider.
- Specialists.
- Hospital staff.
- Home health staff.
- Molina staff.

Dual-Eligible Members: Three-Way Contract
The state's three-way contract guides the coordination for Molina Members enrolled under the Medicare-Medicaid Plan (MMP). The Model of Care includes descriptions of population (including health conditions), Care Coordination, Provider Network, and Quality Measurement and Performance Improvement.

1. **Targeted population**—Molina operates Medicare-Medicaid Plans for Members who are eligible for both Medicare and Medicaid and has a Model of Care that outlines Molina's efforts to meet the needs of the Members enrolled.

2. **Care Management goals**—Utilization of Molina's extensive network of PCPs, specialty Providers, and facilities, in addition to services from the Molina ICM, will improve Molina Members' access to essential services, such as physical health,

behavioral health, and social services. Molina demonstrates its compliance with this goal using the following data to see annual improvement compared to benchmarks:

a. Reports showing availability of services by geographic area.
b. Number of Members utilizing the following services:
    - Primary Care Provider (PCP) services.
    - Specialty (including Behavioral Health) services.
    - Inpatient hospital services.
    - Skilled Nursing Facility services.
    - Home health services.
    - Behavioral Health (BH) facility services.
    - Durable Medical Equipment (DME) services.
    - Emergency Department services.
    - Supplemental transportation benefits.
    - MLTSS.
c. HEDIS® use of services reports.
d. Member Access Complaint report.
e. Medicare CAHPS® survey.
f. Molina Provider Access survey.

3. **Access to quality, affordable health care**—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; Molina expects to see annual improvement compared to benchmarks:
    a. HEDIS® report on percentage of 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.
    g. Medicare/Medicaid sanctions report review.

4. **Access to programs**—By having access to Molina's network of PCPs and specialty Providers, as well as Molina's programs that include Care Management Service Coordination, Nurse Advice Line, Utilization Management and Quality Improvement, Members have an opportunity to improve health outcomes.

    Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks; Molina expects to see annual improvement compared to benchmarks:
    a. Medicare Health Outcomes survey (HOS).
    b. Chronic Care Improvement Program reports.

5. **Coordination of care contact**—Members will have an assigned point of contact for their coordination of care. According to Member's needs and/or preferences, this coordination of care contact may be his/her Molina network PCP or a Molina Care Manager. Care will be coordinated through this single point of contact who interacts with the ICT to coordinate services and ICP reviews/attestations, as needed.

6. **Improved transitions of care across health care settings, Providers and health services—**Molina has programs designed to improve transitions of care. Authorization processes enable Molina staff to become aware of transitions of care as they occur. Molina Care Managers work with Members, their caregiver(s), authorized representative(s), and/or their Providers to ensure all are aware of the transition episode, address risk associated with transition needs, and assist with planning, preparation and follow-up care post-transition. Molina's Transition of Care Program provides follow-up telephone calls or face-to-face visits to Members while the Member is in the hospital, when possible, and/or 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, ensure the Members have an understanding on how to manage their condition, and are able to follow the prescribed discharge plan once they are home. The Care Manager will work with the Member to ensure that they have scheduled a follow-up physician appointment, filled all prescriptions, understands how to administer their medications, and have received the necessary discharge services, such as home health care, Durable Medical Equipment/supplies, and/or physical therapy. 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:
   a. Transition of Care data.
   b. Re-admission within 30 days report.
   c. Provider adherence to notification requirements.
   d. Provider adherence to provision of the discharge plan.

7. **Improved access to preventive health services**—Molina 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 transportation to preventive care appointments.

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

8. **Appropriate utilization of health care services**—Molina employs 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**—Molina has developed its staff structure and roles to meet the needs of our 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 Molina's MMP plan. 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. **Integrated Care Management** (ICM) team is comprised of the following positions and roles:
        i. **Care Review Processor**—Gathers clinical information about transitions in care and authorizations for services, authorizes services within their scope of training and job parameters based upon predetermined criteria, serves as a resource for nursing staff in collecting existing clinical information to assist nursing assessments and care team coordination.
        ii. **Care Review Clinician (LVN/RN)**–Assesses, authorizes, coordinates and evaluates 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. **Care Manager (CM)**—Comprised of disciplines such as Registered Nurses, Licensed Vocational/Practical Nurses, Social Workers, Gerontologists, and other health professionals with appropriate background and experience serving vulnerable populations. Works with the Member to identify and address issues regarding Member's physical health, behavioral health, MLTSS, and social needs; creates, maintains, and updates the Individualized Care Plan (ICP), and assists in the coordination of services. Updates to the ICP are communicated by the CM to the Member, Provider, and participants of the Integrated Care Team (ICT) based on Member preference. Assessing, coordinating, triaging, and evaluating services in conjunction with the Member, Providers, and other team Members based on Member's assessed needs and preferences. The CM supports Members, caregivers, authorized representative(s), and Providers which may include facilitation of

information retrieval from ancillary Providers, consultants, and diagnostic studies for development, implementation, and/or revision of the ICP. The CM continues to work with the Member to identify and address issues regarding Member's physical health, behavioral health, MLTSS, and social needs, and maintains and updates the ICP and assists in the coordination of services. Updates to the ICP are communicated by the CM to the Member, Provider, and participants of the ICT based on Member preference.

iv. **Health Manager**—Serves as a resource for Members and Molina staff Members regarding Health Management Program information and educates Members on how to manage their condition. Assists Members with addressing physical health, behavioral health, functional, and cognitive barriers.

v. **Transition of Care Coach**—Comprised of disciplines such as Registered Nurses, Licensed Vocational/Practical Nurses (LVN), Licensed Practical Nurses (LPN), Social Workers, Gerontologists, and other allied health professionals with appropriate background and experience serving vulnerable populations. Transitions Coach functions as a facilitator of interdisciplinary collaboration across the transition, engaging the Member, authorized representative(s) and caregivers, facility, and Providers to participate in the formation and implementation of an ICP including interventions to mitigate the risk of re-hospitalization. The primary role of the Transitions staff is to follow the Member closely for up to 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(s).

vi. **Community Connectors/Health Workers**—The Community Connectors are community health workers who act as Care Manager Extenders to assist the Member in navigating their health care needs and connect them to community-based resources, education, advocacy, and social support. Community Connectors are Members of the community in which they serve and therefore understand the community's culture, language, and norms. They may assist Members with housing, food, clothing, heating, transportation, scheduling appointments, medication refills, obtaining DME, and identifying community advocates for eligibility/financial needs.

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 ICM and UM 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 benefits, and is comprised of the following positions:
   i. **Member Services Representative**—Initial point of contact to answer Members' questions, assist with benefits information and interpretation, provide information on rights and responsibilities, assist with PCP selection, advocate on the Member's 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 Manager/Director**—Provides oversight for Member Services programs, provides and interprets reporting on Member Services functions, evaluates Member Services department functions, identifies and addresses 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**—Provides Member with information about Appeal and Grievance processes, assists Member in processing appeals and grievances, notifies Member of appeals and grievance outcomes in compliance with CMS regulations.
   ii. **Appeals and Grievances Manager**—Provides oversight of appeals and grievance processes assuring that CMS regulations are followed, provides and interprets reporting on A&G functions, evaluates A&G department functions, identifies and addresses opportunities for improvement.

d. **Quality Improvement (QI) team** that develops, monitors, evaluates, and improves the Molina Quality Improvement Program. QI team is comprised of the following positions:
   i. **QI Specialist**—Coordinates implementation of QI Program, gathers information for QI Program reporting and evaluation, provides 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**–Gathers and validates data for HEDIS® reporting.
   iv. **HEDIS® Manager**—Oversight and coordination of data gathering and validation for HEDIS® reporting, provides and interprets HEDIS® reports, provides preventive services missing services report.

e. **Medical Director team** has Molina-employed board-certified physicians, including a Psychiatric Medical Director:
   i. **Medical Directors and Health Care Services Program Manager**—Responsible for oversight of the development, training, and integrity of Molina's Health Care Services and Quality Improvement Programs. Resource for Integrated Care Management and Utilization Management 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 Health Care 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 Molina-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**—Provides authorizations for Part D medications. Provides oversight of Pharmacy Technician performance, resource for Care Management teams, other Molina staff, and Providers. Reviews post-discharge medication changes, reviews Member medication lists and report data to assure adherence and safety, interacts with Members and Providers to discuss medication lists and adherence.

h. **Health Care Analytics team**
   i. **Health Care Analyst**—Assists in gathering information, developing reports, providing analysis for health plan to meet CMS reporting requirements, evaluate the MOC, and review operations.
   ii. **Director Health Care 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 Members. This team provides population-based Health Management Programs for low-risk Members identified with asthma and depression. The Health Management team is comprised of the following positions:
    i. **Medicare Member Outreach Assistant**—Makes outbound calls related to gathering and giving information regarding Health Management Programs, makes outbound calls to review whether Member received hospital discharge plan, makes referrals to Care/Care Managers when Members have questions about their hospital discharge plan, makes outbound preventive-service reminder calls.

j. **Nurse Advice Line team** a live Registered Nurse is available to receive inbound calls from Members and Providers who have questions about medical care and after-hours issues that need to be addressed, give protocol based medical advice to Members, and direct after-hours transitions in care. The Nurse Advice Line is available 24 hours per day, 7 days per week for Members.

k. **Interdisciplinary Care Team**—Composition of the Interdisciplinary Care Team (ICT): ICT participants are determined by Member preferences or identified needs, and inclusion decisions are made collaboratively and with respect to the Member's needs and rights to self-direct care as applicable. Family member(s) and caregiver participation is encouraged and promoted, with the Member's permission. Members are educated about the ICT process during the assessment and provided instruction on how to access an ICT team Member and how to request a formal ICT meeting. The CM provides invitations either verbally or in writing to ICT participants, and the Member and their PCP are encouraged to participate. The Member may opt out of the ICT meeting and/or choose to limit the role of the participants. including caregivers or other Providers. Collaborators, based on Member preferences and needs, may include but are not limited to:
    - Caregiver/Member representative(s), if applicable.
    - PCP, Nurse Practitioner (NP), Physician Assistant (PA).
    - Care Manager.
    - Molina Medical Director.
    - Other Molina staff, such as social worker.
    - Behavioral Health.
    - Pharmacist, as needed.
    - Molina Transitions of Care staff.
    - Hospitalist/Discharge Planner or SNF/Long-Term Acute Care Facility teams.
    - Molina Community Connectors.
    - Specialty Providers.

- Home Health Providers.
- Behavioral Health Providers.
- Care Managers from county agencies.
- Certified outpatient rehabilitation staff.
- Behavioral Health facility staff.
- Renal dialysis center staff.
- Out-of-network Providers or facility staff (until a Member's condition or the state of the Molina network allows safe transfer to in-network care).

ICT Operations and Communication—The Member's assigned PCP and/or the Molina Care Manager will facilitate and present the majority of the Member's case during formal ICT meetings. The PCP will regularly (frequency depends on the Member's medical conditions and status) address the Member's medical conditions, develop appropriate treatment plans, and request consultations, evaluations, and care from other Providers both within and (when necessary) outside the Molina Network. The Molina Care Manager will work with the Member, Member representative(s), and/or Provider(s) in completing assessments, developing the ICP, and individualized care goals. The PCP is expected to review the Member's Individualized Care Plan (ICP) at creation and every update thereafter. Molina will ensure each Member's PCP has completed the ICP review by tracking and collecting the PCP ICP attestation forms, or when consulting the PCP during formal or informal ICT meetings.

i. The Molina Care Manager will be involved during assessments, ICP creation and follow-up, transitions of care between settings, routine care management follow-up, and significant changes in the Member's health status. In addition, the Member may be referred to Molina's ICM Program by other Molina staff (i.e., UM staff, pharmacists, requests for assistance from PCPs, requests for assistance from Members/caregivers, etc.) when Member needs warrant. Transitions in care and significant changes in health status that need follow-up will be identified when services requiring Prior Authorization are requested by the Member's PCP or other Providers, such as inpatient admits (signaling a transition in care or complex medical need). The PCP and ICT participants will decide when additional ICT meetings are necessary and will schedule them on "as needed" basis.

ii. The ICT will hold regular meetings 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 Care Manager, when referred by their Provider or at the request of the Member/representative/caregiver. All participants of the ICT will be invited to the case conference. The Molina Care Manager will provide a case conference summary for each Member case discussed, when requested by an ICT participant. The summary is then reviewed with the Member to ensure that they are comfortable with the IPC. The ICP is updated with the Member agreement based on the case conference recommendations in alignment with the Provider's treatment plans. Case conference

summaries will be provided to all applicable ICT participants as determined by the Member or their representative upon request.

iii. Communication between ICT participants will be compliant with all applicable HIPAA regulations and will occur in multiple ways including:
- The Molina Care Manager may facilitate sharing of Member's health and MLTSS records from ICT Providers before, during, and after transitions in care settings and during significant changes in the health status of Members, for those health services that require Prior Authorization, or during the course of regular care management activities.
- Through consultations among those involved in the Member's care (as warranted), county BH Care Managers, social workers, psychiatrists, home health workers, PCPs, Molina medical directors, pharmacists, dieticians, medical specialists, MLTSS Providers and agencies, family members, authorized representative(s), and other caregivers.
- Case conference summaries available to all Members and active participants of the ICT based on Member preference.
- Updated ICPs are reviewed and shared with participants in 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.

10. **Provider Network**—Molina maintains a network of Providers and facilities that has a special expertise in the care of dual-eligible Members. This population has a disproportionate share of physical and mental/behavioral health disabilities. Molina's network is designed to provide access to medical care for this population.

Molina's network has facilities with special expertise to care for its Members including:
- Acute care hospitals.
- Long-term acute care facilities.
- Skilled Nursing Facilities (SNFs).
- 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).

Molina has a large community-based network of medical and ancillary Providers, with many having special expertise 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 has a Credentialing Program to ensure all network Providers meet clearly defined criteria and standards. The Credentialing Program outlines criteria and the sources used to verify these criteria for the evaluation and selection of practitioners and facilities for participation in the Molina network. These criteria have been designed to assess a Provider's ability to deliver care. The Credentialing Program defines the criteria that are applied to applicants for initial participation, recredentialing, and ongoing participation in the Molina network. To remain eligible for participation, practitioners must continue to satisfy all applicable requirements for participation. Providers must be recredentialed every 36 months.

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.

Molina 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.

Molina will use nationally recognized, evidence-based clinical practice guidelines. Molina Medical Directors will select clinical practice guidelines that are relevant to the Dual-Eligible Special Needs Plan (D-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. **Communication**–Molina will monitor and coordinate care for Members using an integrated communication system between Members/representative(s)/ caregivers, the Molina ICM, 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 the Provider Portal 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 participants in the ICT, Molina has available audio conferencing and audio/video conferencing (Molina staff only). Most regular and ad-hoc ICT 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 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 participants and/or stakeholders will be documented in the Care Management electronic platform. This documentation allows 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 an electronic Care or Utilization Management platform call-tracking entry or a written summary depending on the situation.
f. Molina committee meetings will result in official meeting minutes that will be archived for future reference.

A designated Molina Quality Improvement Director will have responsibility to oversee, monitor, and evaluate the effectiveness of the Communication Program.

12. **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:
- Administrative (demographics, call center data).
- Authorizations.
- CAHPS®.
- Call tracking.
- Claims.
- Clinical care advance (Care/Case/Disease Management Program data).
- Encounters.
- HEDIS®.
- HOS.
- Medical record reviews.
- Pharmacy.
- Provider Access survey.
- Provider Satisfaction survey.
- Risk assessments.
- Utilization.
- Chronic Disease Self-Management Plan (CDSMP) assessment results.
- Care Management Satisfaction survey.

Molina will use internal Quality Improvement Specialists, external survey vendors, and health care analysts to collect, analyze, and report on the above

data using manual and electronic analysis. Data analyzed and reported will demonstrate the following:

- Improved Member access to services and benefits.
- Improved health status.
- Adequate service delivery processes.
- Use of evidence-based clinical practice guidelines for management of chronic conditions.
- Participation by Members/caregivers and ICT participants in care planning.
- Utilization of supplementary benefits.
- Member use of communication mechanisms.
- Satisfaction with Molina's Care Management Program.

Molina will submit CMS-required public reporting data, including:

- HEDIS® data.
- SNP structure and process measures.
- Health Outcomes survey.
- CAHPS® survey.

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

- Audits of health information for accuracy and appropriateness.
- Member/caregiver education for frequency and appropriateness.
- Clinical outcomes.
- Mental/Behavioral Health/psychiatric services utilization rates.
- Complaints, grievances, services, and benefits denials.
- Disease-management indicators.
- Disease-management referrals for timeliness and appropriateness.
- Emergency Room utilization rates.
- Enrollment/disenrollment rates.
- Evidence-based clinical guidelines or protocols utilization rates.
- Fall and injury occurrences.
- Facilitation of Member developing Advance Directives/health proxy.
- Functional/ADLs status/deficits.
- Home meal delivery service utilization rates.
- Hospice referral and utilization rates.
- Hospital admissions/readmissions.
- Hospital discharge outreach and follow-up rates.
- Immunization rates.
- Medication compliance/utilization rates.
- Medication errors/adverse drug events.
- Medication therapy management effectiveness.
- Mortality reviews.
- Pain and symptoms management effectiveness.
- Policies and procedures for effectiveness and staff compliance.
- Preventive programs utilization rates (e.g., smoking cessation).
- Preventive screening rates.

- Primary care visit utilization rates.
- Satisfaction surveys for Members/caregivers.
- Satisfaction surveys for Provider Network.
- Screening for depression and drug/alcohol abuse.
- Screening for elder/physical/sexual abuse.
- Skilled Nursing Facility placement/readmission rates.
- Skilled Nursing Facility level of care Members living in the community having admissions/readmissions to Skilled Nursing Facilities.
- Urinary incontinence rates.
- 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 Model of Care. Molina will notify stakeholders of improvements to the Model of Care by posting the HEDIS® and CAHPS® Model of Care evaluation results on its website.

13. **Care Management for the most vulnerable subpopulations**—Molina identifies the most vulnerable Members as those who may have experienced a change in health status, transition of care setting, a diagnosis that requires extensive use of resources, or those who need help navigating the health care system due to inadequate social determinants of health. Molina's most vulnerable population includes Members who may be at imminent risk of:
    - An Emergency Department visit.
    - An inpatient admission.
    - Institutionalization related to environmental and/or social issues.
    - Transferring to a home or community setting but are currently institutionalized.
    - Facing an imminent loss of current living arrangement.

    Molina identifies the following vulnerable subpopulations through:
    - Historical data.
    - The assessment process.
    - Monitoring of utilization activity.
    - Member or family report.
    - Provider referral.

    The needs of the most vulnerable population are met within the Model of Care by early identification and higher stratification/priority in the Molina ICM Program. These Members are managed more closely and frequently by the Molina Care Manager and the ICT as warranted, based on the Member's needs and preferences. Close monitoring ensures that Members receive all necessary services and that care plans are updated timely and adequately

before, during, and after transitions in health care settings or changes in health care status.

11. Provider Responsibilities

UPDATE
Ensuring Adequate COVID-19 Safety Protocols for Federal Contractors for Subcontracts Over the Simplified Acquisition Threshold of $250,000.

(a) Definition. As used in this clause, "United States or its outlying areas" means:
(1) The 50 States.
(2) The District of Columbia.
(3) The commonwealths of Puerto Rico and the Northern Mariana Islands.
(4) The territories of American Samoa, Guam, and the United States Virgin Islands.
(5) The minor outlying islands of Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Islands, Navassa Island, Palmyra Atoll, and Wake Atoll.

(b) Authority. This clause implements Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985).

(c) Compliance. The Provider, a subcontractor, shall comply with all guidance—including guidance conveyed through Frequently Asked Questions, as amended during the performance of this Agreement—for contractor or subcontractor workplace locations published by the Safer Federal Workforce Task Force (Task Force Guidance) at saferfederalworkforce.gov/contractors.

(d) Subcontracts. The Provider shall include the substance of this clause, including this paragraph (d), in subcontracts at any tier that exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award, and are for services, including construction, performed in whole or in part within the United States or its outlying areas.

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 (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 Medicare-Medicaid Plan (MMP) 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).

For more information about Nondiscrimination of Health Care Service Delivery, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

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, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802
Toll Free: (866) 606-3889
TTY/TDD: 711
Online: MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Should you or a Molina Member need more information, you can refer to the Health and Human Services website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

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).

Cooperation Between Providers
Molina encourages network Providers and subcontractors to cooperate and communicate with other service Providers who serve Enrollees. Such other service Providers may include WIC Programs, Head Start Programs, Early Intervention Programs, Day Care Programs, and school systems, among others. Such cooperation may include performing annual physical examinations for school and the sharing of information (with the consent of the Enrollee, parent, or legal guardian if the enrollee is underage). Annual health examinations for school include an age-appropriate developmental screening, and an age-appropriate social and emotional screening, as required by Public Act 99-927.

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 Members and Provider Network.

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/PCP 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 30 calendar days in advance 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 practice name, 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 Providersearch.MolinaHealthcare.com to validate and correct most of your information. A convenient Provider web form can be found on the POD and on the Provider Portal at Provider.MolinaHealthcare.com. You can also notify your Provider Network Manager if your information needs to be updated or corrected.

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

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our network of Providers through various methods, such as letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts the Provider Directory or otherwise impacts its Membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

National Plan and Provider Enumeration System (NPPES) Data Verification
CMS recommends that Providers routinely verify and attest to the accuracy of their National Plan and Provider Enumeration System (NPPES) data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages our Provider Network to verify Provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQs) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements
Molina requires Providers to utilize electronic solutions and tools whenever possible.

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 the Provider Portal.

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

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Provider Portal within 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 MolinaHealthcare.com.

Electronic Solutions/Tools Available to Providers
Electronic tools/solutions available to Molina Providers include:
- Electronic claims submission options.
- Electronic payment: EFT with ERA.
- Provider Portal.

Electronic Claims Submission Requirement
Molina strongly encourages Participating Providers to submit claims electronically whenever possible. Electronic claims submission provides significant benefits to the Provider, such as:
- Promoting HIPAA compliance.
- Helping reduce operational costs associated with paper claims (printing, postage, etc.).
- Increasing accuracy of data and efficient information delivery.
- Reducing claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminating mailing time, enabling claims to reach Molina faster.

Molina offers the following electronic claims submission options:
- Submit claims directly to Molina via the Provider Portal: provider.molinahealthcare.com, refer to the Provider Portal Quick Reference Guide at Portal Quick Reference Guide, or contact your Provider Network Manager for registration and claim submission guidance.
- Submit claims to Molina through your EDI clearinghouse using **Payer ID 20934**; refer to our website MolinaHealthcare.com for additional information.

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

Provider Portal claims submission includes the ability to:
- Add attachments to claims.
- Submit corrected claims.

- Easily and quickly void claims.
- Check claims status.
- Receive timely notification of a change in status for a particular claim.
- Ability to save incomplete/unsubmitted 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 in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and 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 processes.

Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices. Additional instructions about how to register are available under the EDI/ERA/EFT tab on Molina's website MolinaHealthcare.com.

Any questions during this process should be directed to Change Healthcare Provider Services at wco.Provider.registration at ChangeHealthcare.com or (877) 389-1160.

Availity Provider Portal
Providers are required to register for (online) and utilize the **no-cost** Availity Provider Portal. The Portal is an easy-to-use, online tool available to all our Providers enabling you to perform many functions online without the need to call or fax Molina. The Provider Portal offers the following functionality:
- Verify and print Member eligibility.
- View benefits, covered services, and Member health records.
- View roster of assigned Molina Members 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 Authorization/Service Request Templates.
- View HEDIS® scores and compare to national benchmarks.
- Appeals:
    - Create and submit a claim appeal.
    - Add appeal attachments to appeal.
    - Receive email confirmation.

Provider Portal
Providers and third-party billers can use the **no-cost** Provider Portal to perform many functions online without the need to call or fax Molina. Registration can be performed online and, once completed, the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services, and view HEDIS® needed services (gaps)
- Claims:
    - Submit professional (CMS-1500) and institutional (UB-04) claims with attached files.
    - Correct/void claims.
    - Add attachments to previously submitted claims.
    - Check claims status.
    - Create and manage claim templates.
    - Create and submit a claim appeal with attached files.
- Prior Authorizations/Service Requests:
    - Create and submit Prior Authorization/Service Requests.
    - Check status of Authorization/Service Requests.
- View HEDIS® Scores and compare to national benchmarks.
- View a roster of assigned Molina Members for Primary Care Providers (PCPs).
- Download forms and documents.
- Send/receive secure messages to/from Molina.

Balance Billing
Per federal law, 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.

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 that are the legal obligation of Molina to the Provider. **Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance, and deductible amounts.**

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 on the Molina website. Refer to Chapter 8 titled "Your Rights and Responsibilities."

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.

For additional information, contact Molina at **(877) 901-8181**, seven days a week, 8 a.m. to 8 p.m., Central Time or TTY/TDD 711.

Second Opinions
If a Member does not agree with the Provider's plan of care, the Member has the right to request, at no cost, 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.

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 approved by Molina prior to use.

Please contact your Provider Network Manager for information and review of proposed materials.

Member Eligibility Verification
Possession of a Molina ID card does not guarantee Member eligibility or coverage. 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.

For additional information, please refer to the Eligibility and Enrollment in Molina Dual Options Plans section of this Provider Manual.

Member Cost-Share
Under no circumstance will Members be liable for any amount owed by Molina to the Provider. Balance billing Molina Members for services covered by Molina is prohibited. This includes asking Members to pay the difference between the discounted and negotiated fees and the Provider's usual and customary fees. In addition, Providers are responsible for verifying eligibility and obtaining approval for services that require prior authorization.

Providers should verify the Molina Member's cost-share status prior to requiring the 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).

Health Care Services (Utilization Management and Care Management)
Providers are required to participate in and comply with Molina's Utilization Management and Care Management Programs, including all policies and procedures regarding Molina's facility admission, Prior Authorization, Medical Necessity review determination, and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

For additional information, please refer to the Health Care Services section of this Provider Manual.

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 MolinaHealthcare.com.

Additional information regarding in-network laboratory Providers and in-network laboratory Provider patient service centers is found on the laboratory Providers' respective websites at QuestDiagnostics.com and LabCorp.com.

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
A referral is necessary 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 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 all referrals in the patient's medical record. Documentation must include the specialty, services requested, and diagnosis for which the referral is being made.

Network Providers should have and maintain admitting privileges and, as appropriate, delivery privileges. In lieu of these privileges, the Provider should have a written referral agreement with a network Provider who has such privileges at a network hospital. The agreement must provide for transfer of medical records and coordination of care between physicians.

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers that are contracted and credentialed (if applicable)

with Molina. In the case of urgent and 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.

For additional information, please refer to the Health Care Services section of this Provider Manual. PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a Prior Authorization.

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.

Maternal Care
Molina requires that all contracted hospitals and birthing centers have policies in place that safely reduce C-sections and Early Elective Delivery (EED). Molina will enable Members to receive timely and evidence-based postpartum care. At a minimum, Molina shall provide and document the following services:

Postpartum visits, in accordance with the HFS' approved schedule, to assess and provide education on areas such as perineum care, breastfeeding/feeding practices, nutrition, exercise, immunization, sexual activity, effective family planning, pregnancy intervals, physical activity, SIDS, the importance of ongoing well-woman care, and referral to parenting classes, maternity education tools, platforms and materials, and WIC.

Pharmacy Program
Providers are required to adhere to Molina's drug formularies and prescription policies. For additional information please refer to the Medicare Part D section of this Provider Manual.

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. Such participation includes, but is not limited to:
- Access to care standards.
- Site and medical record-keeping practice reviews as applicable.
- Delivery of patient care information.

For additional information, please refer to the Quality section of this Provider Manual.

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 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. For additional information, please refer to the Compliance section of this Provider Manual.

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 submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than ten (10) years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information, please refer to the Member Grievances and Appeals section of this Provider Manual.

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 30 days in advance when they relocate or open an additional office.

More information about Molina's Credentialing Program, including Policies and Procedures, is available in the Credentialing 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.

12. Claims and Compensation

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 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. 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) Nonketotic 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 Inpatient Prospective Payment System (IPPS) hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- 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: 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 the Provider Portal whenever possible 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 20934**. 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.

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.
- Place and type of service code.
- Days or units as applicable.
- Provider Tax Identification Number (TIN).
- Ten-digit National Provider Identifier (NPI).
- Rendering Provider name as applicable.
- Billing/pay-to Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service facility location information.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim.

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 30 calendar days from the change.

Electronic Claims Submission
Molina strongly encourages Participating Providers to submit claims electronically, including secondary claims. Electronic claims submission provides significant benefits to the Provider including:

- Helps reduce operations 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 so claims reach Molina faster.

Molina offers the following electronic claims submission options:

- Submit claims directly to Molina via the Provider Portal.
- Submit claims to Molina via your regular EDI clearinghouse using **Payer ID 20934**.

Provider Portal
The Provider Portal is a no-cost online platform that offers several claims-processing features:

- Submit Professional (CMS-1500) and Institutional (UB-04) claims with attached files.
- Correct/void claims.
- Add attachments to previously submitted claims.
- Check claims status.
- Create and manage claim templates.
- Create and submit a claim appeal with attached files.

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 837P for Professional and 837I for Institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure that 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 claim 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
Participating Providers should submit claims electronically. If electronic claim submission is not possible, you may submit paper claims to the following address:

Molina Healthcare of Illinois, Inc.
P.O. Box 540
Long Beach, CA 90806

Please keep the following in mind when submitting paper claims:

- Paper claims should be submitted on original red-colored CMS-1500 claims forms.
- Paper claims must be printed using black ink.

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 COB/TPL is determined, Molina may request recovery post payment if appropriate. 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 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 180 calendar 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 90 calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government

program requirements, any claims that are not submitted to Molina within these timelines shall not be eligible for payment, and Provider hereby waives any right to payment.

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

Molina utilizes a claims adjudication system that encompasses edits and audits that follow state and federal requirements, and administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including Procedure-to-Procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). 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 (NCD).
  - In the absence of state guidance, Medicare Local Coverage Determinations (LCD).
  - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than state and federal guidelines.
- Molina policies based on the appropriateness of health care and Medical Necessity.
- Payment policies published by Molina.

Telehealth Claims and Billing
Providers must follow CMS guidelines, as well as state-level requirements.

All telehealth claims for Molina Members **must** be submitted to Molina with correct codes for the plan type. Use the telehealth Place of Service (POS) code 02, which certifies that the service meets the telehealth requirements. By coding and billing a place of service 02 with a covered telehealth procedure code, the Provider is certifying the Member was present at an eligible originating site when the telehealth services were performed. Modifier GQ is required when applicable. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

National Correct Coding Initiative (NCCI)
CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina Healthcare, Inc. uses NCCI standard payment methodologies.

NCCI procedure-to-procedure edits prevent inappropriate payment of services that should not be bundled or billed together and promote correct coding practices. Based on NCCI Coding Manual and CPT Guidelines, some services/procedures performed in conjunction with an Evaluation and Management (E&M) code will bundle into the procedure when performed by same physician, and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUE), which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements
Correct coding is required to properly process claims. Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes
Codes must be submitted in accordance with the chapter- and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the Date of Service (DOS) for which the procedure or service was rendered and **not** the date of submission.

Modifiers
Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component.
- Service or procedure has a technical component.
- Service or procedure was performed by more than one physician.

- Unilateral procedure was performed.
- Bilateral procedure was performed.
- Service or procedure was provided more than once.
- Only part of a service was performed.

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS codebooks.

ICD-10-CM/PCS codes
Molina utilizes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules, and will deny claims that do not meet Molina's ICD-10 Claim Submission guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and **not** the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes
Place of Service Codes (POS) are two-digit codes placed on health care professional claims (CMS-1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

Type of Bill
Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official UB-04 Data Specifications Manual.

Revenue Codes
Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official UB-04 Data Specifications Manual.

Diagnosis Related Group (DRG)
Facilities contracted to use DRG payment methodology submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment.

Molina processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if

applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code (NDC)
The 11-digit National Drug Code (NDC) number must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04, or its electronic equivalent.

Providers will need to submit claims with both HCPCS and NDC codes with the exact NDC that appears on the medication packaging in the "5-4-2 digit" format (i.e., xxxxx-xxxx-xx), as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

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. It has 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 and Prevention (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
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.

Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and 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 as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This sample gives an estimate of the proportion of claims Molina paid in error. The estimated proportion, or error rate, may be projected across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews, and may be vendor assisted. Molina asks that you provide us, or our designee, during normal business hours, access to examine, audit, scan, and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Corrected Claims
Corrected claims are considered new claims for processing purposes. Corrected claims must be submitted electronically with the appropriate fields completed on the 837I or 837P. The Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is a replacement of prior claim or corrected claim for an 837I or the correct resubmission code for an 837P and include the original claim number.

Important: 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
A complete claim is a claim that has no defect, impropriety, or lack of any required substantiating documentation as outlined in "Required Elements" above, or particular

circumstance requiring special treatment that prevents timely payment from being made on the claim.

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 as follows:

- 95% of the monthly volume of non-contracted clean claims are to be adjudicated within 30 calendar days of receipt.
- 95% of the monthly volume of contracted claims are to be adjudicated within 60 calendar days of receipt.
- 95% of the monthly volume of non-clean, non-contracted claims shall be paid or denied within 60 calendar days of receipt.

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, provide 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 MolinaHealthcare.com or by contacting our Provider Network Management 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 time frame 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 seeking a redetermination of a claim previously adjudicated must request such action in writing, utilizing Molina's Provider Research and Resolution process within 90 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 the following methods:

- **Provider Portal**: Providers may submit their appeals and disputes along with supporting documentation through the Provider Portal. The Portal can be accessed on the Molina Provider home page at MolinaHealthcare.com.
- **Fax**: A Claims Dispute Request form is required when submitting via fax. The completed Claims Dispute Request forms, along with supporting documentation, may be faxed to Molina at **(855) 502-4962**. The Claims Dispute Request form is on Molina's Provider website at: MolinaHealthcare.com.
- Email to MHILProviderNetworkManagement@MolinaHealthcare.com.

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

All questions pertaining to claim redetermination requests are to be directed to the Provider Network Management team.

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.

Balance Billing
Per federal law, 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.

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 that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is **prohibited**, other than for the Member's applicable copayment, coinsurance, and deductible amounts.

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 Provider, capitated Provider, or 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, risk adjustment, hospital rate setting, the Quality Improvement Program, and HEDIS® reporting.

Encounter Data must be submitted at least once per month, and within 30 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: 837I for Institutional, 837P for Professional, and 837D for Dental. Data must be submitted with claims level detail for all non-institutional services provided.

Molina has a comprehensive automated and integrated Encounter Data system capable of supporting all 837 file formats and proprietary formats if needed.

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

Molina has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When encounters are filed electronically Providers should receive two types of responses:
- First, Molina will provide a 999 acknowledgement of the transmission.
- Second, Molina will provide a 277CA response file for each transaction.

13. Credentialing and Recredentialing

Uniform Credentialing and Recredentialing

If the practitioner is not enrolled in IMPACT, practitioner must follow Molina's credentialing and recredentialing process.

In accordance with 42 CFR 438.214, Provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and recredentialing process. To participate in Molina's Provider Network, Molina must verify that practitioner is enrolled in IMPACT. Molina will submit monthly reports to the Illinois Department of Healthcare and Family Services (HFS) indicating which practitioners have completed the credentialing process and the results of the process.

14. 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 used to determine the category of the complaint are:
   - The grievance process will be used for complaints concerning involuntary 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 and will thoroughly investigate, track, and process the grievance within 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 24 hours.
     Complaints concerning the timely receipt of services already provided are considered grievances.

3. **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 (HACs), and Never Events. Members may also file care complaints with the state's contracted and CMS-assigned Quality Improvement Organization.

4. **Organization Determination**—Organization determinations are any determination (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 Health Care 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.

5. **Part D Appeals**—Please see the Medicare Part D section of this Provider Manual.

6. **Provider Claim Redeterminations**—Please see the Claims and Compensation section of this Provider Manual.

Definition of Key Terms used in 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 Network Manager.

Appeal—Any of the procedures that deal with the review of adverse organization determinations on the health care services a Member believes he/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, the 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, the respect paid to Members, the claims regarding the right of the Member to receive services or to receive 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/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's 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 at 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.
- 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 (M&PCC) toll free at **(877) 901-8181** 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 M&PCC.

There are Two Kinds of Appeals Members Can File

- **Standard Appeal**—Members can ask for a standard appeal. Molina must give the Member a decision within 15 business days after Molina receives the Member's appeal. Molina may extend this time by up to 14 days if the Member requests an extension, or if Molina needs additional information and the extension benefits the Member.

- **Expedited Appeal**—Members can ask for an expedited appeal if they believe that their health could be seriously harmed by waiting too long for a decision. Molina will notify the Member within 24 hours after the submission of the appeal, of all information from the Member that Molina requires to evaluate the expedited appeal. Molina shall render a decision on an expedited appeal within 24 hours after receipt of the required information.

What to Include With the Appeal
Members should include their name, address, contact information, Member ID number, reason for appealing, and any evidence the Member wishes to attach. Members may send in supporting medical records, documentation, or other information that explains why Molina should provide service.

How To File an Appeal

For standard appeal, Members should mail, deliver, or fax a written appeal to Molina:

Molina Healthcare, Inc.
Attn: Grievance and Appeals
P.O. Box 22816
Long Beach, CA 90801-9977

Fax: (562) 499-0610
Telephone: (877) 901-8181

Hours of Operation: Monday through Sunday, 8 a.m. to 8 p.m., local time.

15. 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 his/her personal representative to act on his/her behalf. After the date of the denial, a Member has up to 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 days. If an expedited appeal is required for an emergent situation, then the decision will be made within 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 60 days of receipt of the appeal. The IRE has seven days to make a decision for a standard appeal/reconsideration and 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 72 hours.

If the IRE changes the Molina decision, authorization for service must be made within 72 hours for standard appeals and within 24 hours for expedited appeals.

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

If the IRE upholds Molina's denial, it will inform the Member of his/her 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 MAXIMUS 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 (which can include Providers and pharmacists) may call, write, fax, or email 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 at **(800) 665-4621** or **fax (866) 472-0596**.

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 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 per CMS.
   - Co-payments for Molina 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 some of which 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.
   - **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 P&T Committee.

4. **Non-Covered Molina Medicare Part D Drugs**—The following are **not** covered under Part D:
   - 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. **Possible 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 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 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 60 calendar days from the date that the determination was rendered.
   - A standard appeal may be submitted to Molina in writing. The appeal will be reviewed upon receipt, and the Member will be notified in writing within seven calendar days from the date the request for redetermination is received.
   - An expedited appeal can be requested by the Member or by a Provider acting on behalf of the Member in writing or can be taken over the phone. 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 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 calendar days.
   - A Claims Dispute Request Form is required when submitting via fax. The completed Claims Dispute Request Form, along with supporting documentation may be faxed to Molina at **(855) 502-4962**. The Claims Dispute Request Form may be accessed on Molina's website at: molinahealthcare.com/Providers/il/PDF/Medicaid/Claims_Dispute_Request_Form.pdf

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 via fax and telephone. All requests will be determined, and an

approval or denial decision will be communicated to the Member and the Member's prescribing Provider within 72 hours/three 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 within the following compendia:
   - American Hospital Formulary Service Drug Information.
   - DRUGDEX Information System.

b. Requests for off-label use of medications will need to be accompanied with excerpts from one of the two CMS-required compendia for consideration. The submitted excerpts must cite 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 appeals process.

If Molina denies coverage of the prescribed medication, Molina will give the Member a written notice within 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 time frame, Molina will start the next level of appeal by sending the coverage determination request to the IRE within 24 hours.

If a coverage determination is expedited, Molina will notify the Member of the coverage determination decision within the 24-hour time frame by telephone and will mail the Member a written expedited coverage determination within three 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 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 redetermination within 60 calendar days from the date of the notice of the coverage

determination. In a Standard Appeal, Molina has up to seven days to make the redetermination, whether favorable or adverse, and notify the Member in writing within seven calendar days from the date the request for redetermination is received. Member or a Member's prescribing Provider may request Molina to expedite a redetermination if the standard appeal time frame of seven days may seriously jeopardize the Member's life, health, or ability to regain maximum function. Molina has up to 72 hours to make the redetermination, whether favorable or adverse, and notify the Member in writing within 72 hours after receiving the request for redetermination. If additional information is needed for Molina to make a redetermination, Molina will request the necessary information within 24 hours of the initial request for an expedited redetermination. Molina will inform the Member and prescribing Provider of the conditions for submitting the evidence, since the time frame is limited on expedited cases.

10. **The Part D Independent Review Entity (IRE)**—If the redetermination 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 days to make the decision.
    - **Expedited Appeal:** The IRE has up to 72 hours 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 time frame 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 time frame is not applicable on this level of appeal.
    - **Federal District Court (FDC)**—If the MAC's decision is unfavorable, the Member may appeal to an FDC if the amount in controversy requirement is satisfied. **Note**: Regulatory timeframe is not applicable on this level of appeal.

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, which are 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 MolinaHealthcare.com under the Health Resources tab. Please consult with your Provider Network Manager or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

16. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

- Medical management.
- Credentialing and recredentialing.
- Sanction monitoring for employees and contracted staff at all levels.
- Claims.
- Complex case management.
- CMS preclusion list monitoring.
- Other clinical and administrative functions.

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC) or other designated committee must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

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 Molina.

Corrective Action Plans and Revocation of Delegated Activities
If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that this is the best course of action.

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