# PROVIDER MANUAL
## (Provider Handbook)

## Molina Healthcare of California, Inc.
**(Molina Healthcare or Molina)**

## Medi-Cal
## 2023

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Molina Healthcare. “Molina Healthcare” or “Molina” have the same meaning as “Health Plan” in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

**Important Notice:** Please be aware that if you are a California resident, you have new privacy rights with respect to the business contact information that you share with Molina as a provider. For more details, please see the “Business Contact Information” section on page [317].

Last Updated: 01/2023

MOLINA® HEALTHCARE

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# 1. CONTACT INFORMATION

**Molina Healthcare of California**
**200 Oceangate. Suite 100**
**Long Beach CA, 90802**

## Pediatric/California Children Services (CCS) /Regional Center Team

The Pediatric/CCS/Regional Center Team coordinates referrals to CCS offices and manages the coordination of care for Members with CCS or Regional Center eligible diagnosis and conditions. It also manages general questions about pediatric member issues.

Healthcare Services: Pediatric/CCS/RC Team
Phone: (888)665-4621
Fax: (505) 811-4804924-8267

## Child Health and Disability Prevention (CHDP)/Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)

The Molina Child Health and Disability Prevention (CHDP)/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services Department handles all CHDP/EPSDT Wellness Services andcollects data from Encounter/Claims submissions for CHDP/EPSDT P4P incentive payments from Primary Care Practitioners to ensure the receipt of incentive payouts by MHC.

All providers should submit timely claims and/or encounterdata through normal and current reporting channels to ensure the receipt of the CHDP/EPSDT Wellness Services: http://www.MolinaHealthcare.com

Molina Healthcare of California
P.O. Box 16027
Mailstop “HFW”
Long Beach, CA 90806

Attn: CHDP/EPSDT Department

Phone: (800) 526-8196,
Fax: (562) 499-6117

## Provider Services Department

The Provider Services department handles telephone and written inquiries from Providers regarding issue resolution, provider education and training. The department has Provider Services representatives who serve all of Molina’s Provider network.

Availity Essentials portal: provider.MolinaHealthcare.com

| Service County Area | Provider Services Representative | Contact Number | Email Address |
|---|---|---|---|
| San Diego / Imperial County | Carlos Liciaga | 858-614-1591 | Carlos.Liciaga@molinahealthcare.com |
| Los Angeles | Clemente Arias | 562-517-1014 | Clemente.Arias@molinahealthcare.com |
| California Hospital Systems | Deletha Foster | 909-577-4351 | Deletha.Foster@molinahealthcare.com |
| Sacramento | Jennifer Rivera Carrasco | 562-542-2250 | Jennifer.RiveraCarrasco@molinahealthcare.com |
| San Bernardino | Luana McIver | 909-501-3314 | Luana.Mciver@molinahealthcare.com |
| California Hospital Systems | Shelly Lilly | 858-614-1586 | Michelle.Lilly@molinahealthcare.com |
| San Bernardino/ Riverside County | Vanessa Lomeli | 909-577-4355 | Vanessa.Lomeli2@molinahealthcare.com |
| San Diego / Imperial County | Salvador Perez | 562-549-3825 | Salvador.Perez@molinahealthcare.com |
| Los Angeles / Orange County | Maria Guimoye | 562-549-4390 | Maria.Guimoye@molinahealthcare.com |
| San Diego/ Imperial County | Briana Givens | 562-549-4403 | Briana.Givens@molinahealthcare.com |

**Provider demographic changes, including additions, terminations, and updates should be emailed to the following County mailboxes:**

- Los Angeles: MHC_LAProviderServices@MolinaHealthcare.com
- Sacramento: MHCSacramentoProviderServices@MolinaHealthcare.com
- San Bernardino: MHCIEProviderServices@MolinaHealthcare.com
- Riverside: MHCIEProviderServices@MolinaHealthcare.com
- San Diego: MHCSanDiegoProviderServices@MolinaHealthcare.com
- Imperial: MHCImperialProviderServices@MolinaHealthcare.com

## 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 8:00 am – 8:00 pm local time zone Monday through Friday, excluding State holidays. **Eligibility verifications can be conducted at your convenience via the Availity Essentials portal.**

Phone: (888) 665-4621
Fax: (310) 507-6186
Hearing Impaired: (TTY/TDD) 711

### Claims Department

Molina strongly encourages Participating Providers to submit Claims electronically (via a clearinghouse or the Availity Essentials portal) whenever possible.

- Access the Availity Essentials portal at provider.MolinaHealthcare.com

EDI Payer ID: 38333
Phone: (877) 469-3263

Fee-For-Service Online Claim Submissionthrough Availity Essentials portal: provider.MolinaHealthcare.com

To verify the status of your Claims, please use the Availity Essentials portal. Claims questions can be submitted through the chat feature on the Availity Essentials portal or by contacting Provider Services.

### Claims Recovery Department

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

Claims Recovery correspondence mailing address:

Molina Healthcare of California, Inc.
Claims Recovery Department
PO Box 2470
Spokane, WA 99210-2470

Phone: (866) 642-8999

## Compliance and Fraud AlertLine

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

Confidential
Compliance Official
Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Online: MolinaHealthcare.alertline.com

## Community Engagement

The Community Outreach staff provides outreach and organizes participation in community events such as health fairs, presentations, and local participation in local collaborative or coalition meetings.

Phone: (855) 665-4621 (MOLINA1)
Fax: (909) 890-4403

## 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: (888) 562-5442
Fax: (888) 665-4629

## Cultural and Linguistic Services

The Cultural & Linguistic Services Department provides interpreter services and makes available cultural and linguistic consultation and trainings to assist providers in delivering culturally competent care.

Interpreter Services Information:

Phone: (888) 665-4621 Monday to Friday, 7a.m. to 7p.m.

## Department of Managed Health Care (DMHC)

The Department of Managed Health Care (DMHC) is the state regulatory body that licenses and oversees health maintenance organizations. DMHC accepts complaints regarding health plans by telephone. If a beneficiary has a grievance, he/she should contact the Plan and use the Plan'sgrievance process.

CA Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Phone: (877) 525-1295
E-mail: plans-providers@dmhc.ca.gov

## Department of Social Services (DSS)

The DSS Public Inquiry and Response unit handles inquiries from Medi-Cal beneficiaries regarding fairhearings.

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

Phone: (800) 952-5253
Hearing Impaired (TTY/TTD): (800) 952-8349

## Emergency Department Support Unit (EDSU)

The EDSU is a dedicated team of MHC Registered Nurses, available 24/7 to provide support in placement, issuing authorizations, facilitating Peer to Peer reviews, coordinating and facilitating placement, discharge planning needs, and Member follow-up.

Molina Healthcare of California EDSU
24/7 including weekends and holidays: (844) 966-5462
Fax ED notification to: (877) 665-4625

## Eligibility List Distribution

The Provider Services department is responsible for distribution of eligibility rosters (reports) on a monthly basis to all direct Primary Care Practitioners and IPA/Medical Groups.

Molina Healthcare of California

200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (855) 322-4075

Los Angeles Fax: (855) 278-0312

Sacramento Fax: (916) 561-8559

Riverside/San Bernardino Fax: (909) 890-4403

San Diego Fax: (858) 503-1210

Imperial Fax: (760) 679-5705

## Eligibility Verification

The Member Services Department verifies both Member eligibility and PCP assignment.

Phone: (888) 665-4621, option 1
IVR: (800) 357-0172
Fax: (310) 507-6186

**Eligibility verifications can be conducted at your convenience via the Availity Essentials portal.**

## Encounter Data

The Encounter Data Department handles all encounters for capitated services.

Email: MHCEncounterDepartment@MolinaHealthcare.com

## Facility Site Review

The Facility Site Review is conducted as part of PCP credentialing process. Members are not assigned until a facility has passed the site review. A Periodic Facility Site Review (re-review) is conducted at the time of re-credentialing every three years.

Phone: (800) 526-8196, ext. 120118
Fax: (844) 303-0460

Email: MHCFacilitySiteReview2@MolinaHealthCare.Com

## Health Care Options (HCO)

The Health Care Options Contractor processes Medi- Cal Managed Care enrollments and disenrollment's. Please refer Members to the HCO call-in number.

Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

Phone: (800) 430-4263

## Health Education

The Health Education Department assist Members and Providers in accessing health education and disease management programs and services (e.g., smoking cessation, weight control).

Phone: (866) 472-9483

## Nurse Advice Line

This telephone-based Nurse Advice Line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week to assess symptoms and help make good health care decisions.

English Phone: (888) 275-8750
Spanish Phone: (888) 275-8750
Hearing Impaired: (TTY/TDD) 711

## Healthcare Services Department

The Healthcare Services (formerly Utilization Management) department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The Healthcare Services (HCS) department also provides Care Management for Members who will benefit from Care Management services and programs. Participating Providers are requested 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, including the following:

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

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

- Submit requests directly to Molina via the Availity Essentials portal.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Availity Essentials portal: https://provider.MolinaHealthcare.com
Phone: (844) 557-8434

Prior Authorization: (844) 557-8434
Fax: (800) 811-4804

## Healthcare Services Authorizations & Inpatient Census

Availity Essentials portal: https://provider.MolinaHealthcare.com

Address:

Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (844) 557-8434
Fax: Inpatient: (866) 553-9623
Prior Authorization: (800) 811-4804

## Health Management

Molina's Health Management programs are incorporated into the Member's treatment plan to address the Member's health care needs.

Phone: (866) 891-2320

## Inpatient Review

Registered Nurses and Medical Directors perform initial and concurrent review and provide authorization for admission/continued stay of Members in inpatient settings including acute, SNF, LTC, LTAC, Acute Rehab and Custodial. Notification to Molina is required within twenty-four (24) hours of inpatient admission.

Fax Medi-Cal (clinical documentation): (866) 553-9263
Phone: (844) 557-8434
24/7, Afterhours, Weekends, Holidays call: (844) 966-5462

## Behavioral Health

Molina manages all components of Covered Services for mild/moderate behavioral health needs. Members with severe/persistent mental health conditions who require a higher level of care and treatment receive specialty mental health services (SMHS), through the county mental health plan (MHP). Substance use disorder (SUD) treatment is also a carve-out service that is provided by the county. Molina and network providers will coordinate care with our partners at local county mental health agencies for those members accessing services through the county delivery system. For Member behavioral health needs, please contact us directly at (855) 322-4075. Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Nurse Advice Line telephone number on the back of their Molina ID card.

## Pharmacy Department

Most prescription drugs are covered by Medi-Cal Rx, a Medi-Cal FFS program. This includes any medications that a member obtains from a pharmacy. Providers can prescribe drugs from the Medi-Cal Rx Contract drug list Medi-Cal Rx | Contract Drugs List (CDL), or if a drug is not on the contract drug list, the Provider will need to get approval (prior authorization) from Medi-Cal Rx before the Member can obtain the drug at a pharmacy.

The Medi-Cal Rx PA Request Form can be found on the Medi-Cal Rx website at: Availity Essentials portal: provider.MolinaHealthcare.com and then selecting Forms and Information. Alternate Prior Authorization request forms that may be accepted by Medi-Cal Rx are forms 50-1, 50-2, and 61-211.

To find out if a drug is on the Contract Drug List or to get a copy of the Contract Drug List, call Medi-Cal Rx at 800-977-2273 (TTY/TDD 800-977-2273 and press 5 or 711), or you can visit the Medi-Cal Rx website at: https://medi-calrx.dhcs.ca.gov/home/
Providers can submit drug requests to Medi-Cal Rx by:

Fax: (800) 869-4325
Medi-Cal Rx Portal: www.medi-calrx.dhcs.ca.gov/provider/login
CoverMyMeds: www.covermymeds.com

Mail:

Medi-Cal Rx Customer Service Center
Attn: PA Request
P.O. Box #730
Rancho Cordova, CA 95741-0730

Physician Administered Drugs are partially carved out, meaning those medications could be submitted to Medi-Cal Rx or to Molina.

If the member will obtain the medication from a pharmacy, the Provider can submit the request to Medi-Cal Rx, as noted above.

If the member will be getting the medication by having the provider administer the drug in his/her office, the Provider will be billing Molina for the drug. If the medication requires prior authorization, the Provider can submit the request to Molina, at the fax number below using the 61-211 PA form available on the Molina website. -

Phone: (855) 322-4075
Fax: (866) 508-6445

## Prior Authorization

Molina adheres to the regulatory timeframes as required by DHCS. Prior authorization decisions are completed within five business days for standard requests, and within 72 hours for expedited requests. Timeframes for standard requests may be extended in the event of a delay of receipt of complete information.

Prior Authorization Fax: (800) 811-4804
Phone: (844) 557-8434

## Provider Dispute Resolutions

The Provider Dispute Resolution unit is responsible for providing a fast, fair and cost-effective dispute mechanism to process and resolve contracted and non-contracted provider disputes. Formal disputes must be submitted in writing with supporting documentation.

Molina Healthcare of California
P.O. Box 22722
Long Beach, CA 90801

Attn: Provider Dispute Resolution Unit

## Quality

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

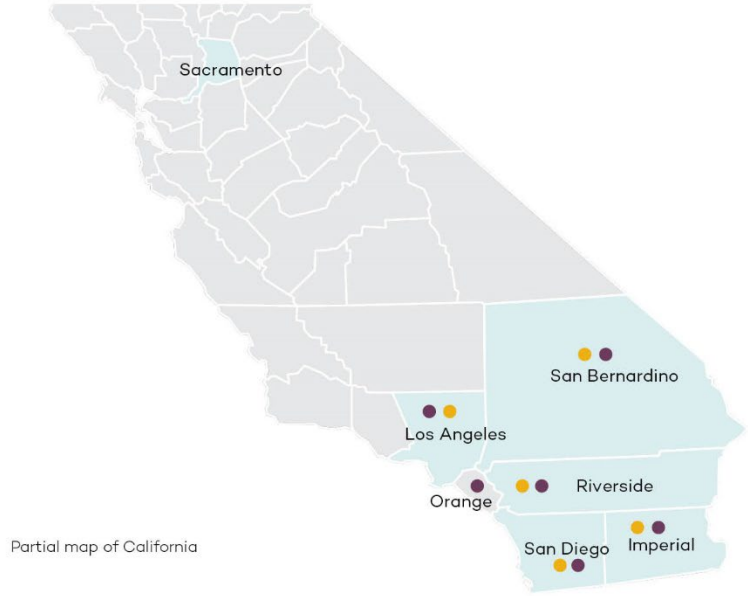
Phone: (800) 526-8196, Ext 126137
Fax: (562) 499-6185

## Vision Care

Molina has contracted with March Vision Care Group for optometry and optical services.

Customer Service: (844) 336-2724

## Molina Healthcare of California Service Area




**Molina Operates in 7 Counties**

- Medi-Cal
- Medicare
- Marketplace

## CONTACTS: IMPERIAL COUNTY

**Molina Healthcare of California**
**Imperial Regional Office**

Tel: (855) 322-4075

Send correspondence to:

200 Oceangate Ste. 100
Long Beach, CA 90802

Attn: Provider Services

**Access to Independence of Imperial Valley**
321 Wake Ave
El Centro, CA 92243

Tel: (760) 768-2044
Fax: (442) 283-5020
www.accesstoindependence.org

**Alternatives for Seniors**

Tel: (800) 350-0770
www.AlternativesforSeniors.com

**Area Agency on Aging (AAA)**
778 W. State St.
El Centro, CA 92243

Tel: (442) 265-7000 or (442) 265-7042
http://www.co.imperial.ca.us/AreaAgencyAging/

**California Children's Services**
935 Broadway St.
El Centro, CA 92243-2396

Tel: (442) 265-1455
Fax: (442) 265-1481

**Deaf Community Services of Imperial County**
1545 Hotel Circle South, Ste. 300
San Diego CA 92108

Video: (619) 398-2441
Tel: (619) 550-3436

Email: info@dcsofsd.org
Website: www.deafcommunityservices.org/

**Health Consumer Center of Imperial Valley**
449 Broadway Street
El Centro, CA 92243

Tel: (760) 353-0220
Fax: (760) 353-8026

**Imperial County Behavioral Health Services**
2695 S. 4th St.
El Centro, CA 92243

Tel: (442) 265-1525 or (800) 817-5292

**Imperial County Behavioral Health Services: Adult Alcohol and Drug Recovery Program**
2695 S. 4th Street
El Centro, CA 92243

Tel: (442) 265-7650

**In-Home Support Services (Imperial County Dept. of Social Services)**
1755 Main St.
El Centro CA 92243

Tel: (760) 337-7722
Fax: (760) 336-3971
www.imperialcounty.net (search for “In-Home Support Services”)

**Meals on Wheels - Imperial County**
1755 Main St.
El Centro, CA 92243

Tel: (442) 265-7000
Fax: (442) 265-7042
www.meals-on-wheels.org

**San Diego Regional Center**
512 W Aten Rd.
Imperial CA 92123-1648

Tel: (760) 355-8150
www.sdrc.org/

# CONTACTS: LOS ANGELES COUNTY

**AIDS Waiver Agency**

AIDS Project Los Angeles
3550 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010

Tel: (213) 201-1422

**Calif. Children's Services (CCS) Program**

County Department of Health
9320 Telstar Avenue, Suite 226
El Monte, CA. 91731-2849

Tel: (800) 288-4584
Fax: (855) 481-6821

**Child Health & Disability Prevention (CHDP) Program**

**Los Angeles County CHDP Program Office**

City of Los Angeles (PM 160 Code: 352M)
9320 Telstar Avenue, Suite 226
El Monte, CA. 91731

Tel: (800) 993-2437
Fax: (626) 569-9350

**City of Long Beach - Health Department**
2525 Grand Avenue
Long Beach, CA 90815

Tel: (562) 570-4000

**Comprehensive Perinatal Services Program CPSP**
600 South Commonwealth, Suite 800
Los Angeles, CA 90005

Tel: (213) 639-6419
Fax: (213) 639-1034

**Los Angeles County Department of Mental Health**
550 South Vermont Avenue
Los Angeles, CA 90020

Tel: (800) 854-7771

**Los Angeles County Department of Public Health - Substance Abuse Prevention and Control**
1000 S. Fremont Avenue, Bldg. A-9 East, 3rd Floor
Alhambra, CA 91803

Tel: (844) 804-7500

**Regional Centers**
Eastern LA Regional Ctr 1000 S. Fremont Ave
Alhambra, CA. 91802-7916

Tel: (626) 299-4700

**Frank D. Lanterman Reg. Ctr**
3303 Wilshire Blvd. Suite 700
Los Angeles, CA. 90010-2197

Tel: (213) 383-1300

**Harbor Regional Ctr**
21231 Hawthorne Blvd.
Torrance, CA. 90503

Tel: (310) 540-1711

**North LA Regional Ctr**
200 Oakdale Ave Suite 100
Chatsworth, CA 91311

Tel: (818) 778-1900

**San Gabriel/Pomona Reg. Ctr**
75 Rancho Camino Drive
Pomona, CA 91766

Tel: (909) 620-7722

**South Central LA Regional Ctr**
2500 S. Western Avenue
Los Angeles, CA 90018

Tel: (213) 744-7000

**Westside Regional Ctr**
5901 Green Valley Circle, Suite 320
Culver City, CA. 92030-6953

Tel: (310) 258-4000

**TB Control Program**
2615 S. Grand Avenue, Room 507
Los Angeles, CA 90007

Tel: (213) 745-0800
Fax: (213) 749-0926

**Women, Infant, & Children (WIC)**
Antelope Valley Tel: (661) 949-5805
Long Beach Tel: (562) 570-4242
Harbor UCLA Tel: (310) 661-3080
Irwindale Tel: (626) 856-6600
Northeast Valley Tel: (818) 361-7541
Pasadena Tel: (626) 744-6520
Watts Tel: (323) 568-3070

# CONTACTS: HEALTH NET

Molina Healthcare of California is sub-contracted under Health Net in Los Angeles County for the Medi-Cal program. As such, Members who are Medi-Cal beneficiaries enrolled in Molina Healthcare in Los Angeles County must contact Health Net's Member Services department for member related issues or inquiries. Health Net will coordinate as appropriate with Molina Healthcare of California to effectively respond to and resolve member issues.

### Health Net Member Services (Medi-Cal Los Angeles)

Tel:(800)-675-6110

### Molina Member Services (Medi-Cal- Riverside County and San Bernardino County)

Tel: (888)-665-4621

### Health Net Nurse Advice Line

The Nurse Advice Line is staffed after business hours by registered nurses for Member assistance and referral.

Tel: (800) 675-6110

### Health Net Website

Health Net's website offers information on member eligibility, claim status, Health Net reference materials such as the Medi-Cal Recommended Drug List, Evidence of Coverage, county-specific Medi-Cal operations manuals, forms, and information on how to contact Health Net with questions.

provider.healthnet.com

### Health Net Community Resource Centers

Get help with insurance questions and enrollment forms. Plus, learn about health classes and many other community resources.

East Los Angeles Tel: (323) 415-9120

### Medicare Advantage Plans

Health Net Amber, Complete, Green, Gold Select, Healthy Heart, Jade, Ruby, Ruby Select and Sapphire

Tel: (800) 949-3022, option 1
Hearing Impaired (TTY/TDD): 711

## Acupuncture Services

Acupuncture services are covered through American Specialty Health Plans, Inc. (ASH Plans) for Health Net Medi-Cal Members. Physicians and capitated participating physician groups (PPGs) must refer Medi-Cal Members to ASH Plans for acupuncture benefits. To refer a Health Net Medi-Cal Member to an ASH preferred provider, contact ASH Plan provider services at: 1-800-972-4226, option 2.

## Claims

Send written correspondence, claims, tracers, adjustment requests, or denial reconsiderations to Health Net Medi-Cal Claims at the following address:

PO Box 14598
Lexington, KY 40512-4598

## Communications

The Health Net National Provider Communications Department informs Health Net participating providers of Health Net's policies and procedures, and changes in contractual, legislative and regulatory requirements through provider operations manuals, updates, letters, and Online News articles.

12009 Foundation Place, Ste. 100, Bldg. B,
Rancho Cordova, CA 95670

Tel: (916) 935-8346
Fax: (800) 937-6086

## Cultural and Linguistic Services

The C&L Services Department promotes access to care for Members who speak a primary language other than English and can help facilitate interpretation services.

cultural.and.linguistic.services@healthnet.com

Tel: (800) 977-6750
Fax: (818) 543-9188

## Delegation Oversight

The Health Net Delegation Oversight Department oversees participating providers in all Health Net lines of business and assists them in understanding and complying with Health Net's requirements and those of state and federal regulatory agencies.

Fax: (866) 476-0311

## Electronic Data Interchange (EDI) Claims

Health Net encourages participating providers to review all electronic claim submission acknowledgment reports regularly and carefully. Questions regarding accessing these reports should be directed to the vendor or clearinghouse. All other questions regarding electronic claims submission should be directed to Health Net's EDI Department.

Tel: (800) 977-3568

## Eligibility Verification

Health Net's Medi-Cal Provider Services Center verifies member eligibility 24 hours a day, seven days a week, 365 days a year. Eligibility can also be verified online through Health Net's website at: www.healthnet.com.

Tel: (800) 675-6110

## Encounters

Contact the Health Net Encounter Department via email with encounter data questions Enc_Group@healthnet.com.

## Enrollment Services

Health Net's Enrollment Services Department is available to Medi-Cal Members to answer any questions regarding benefits and enrollment.

Tel: (800) 327-0502

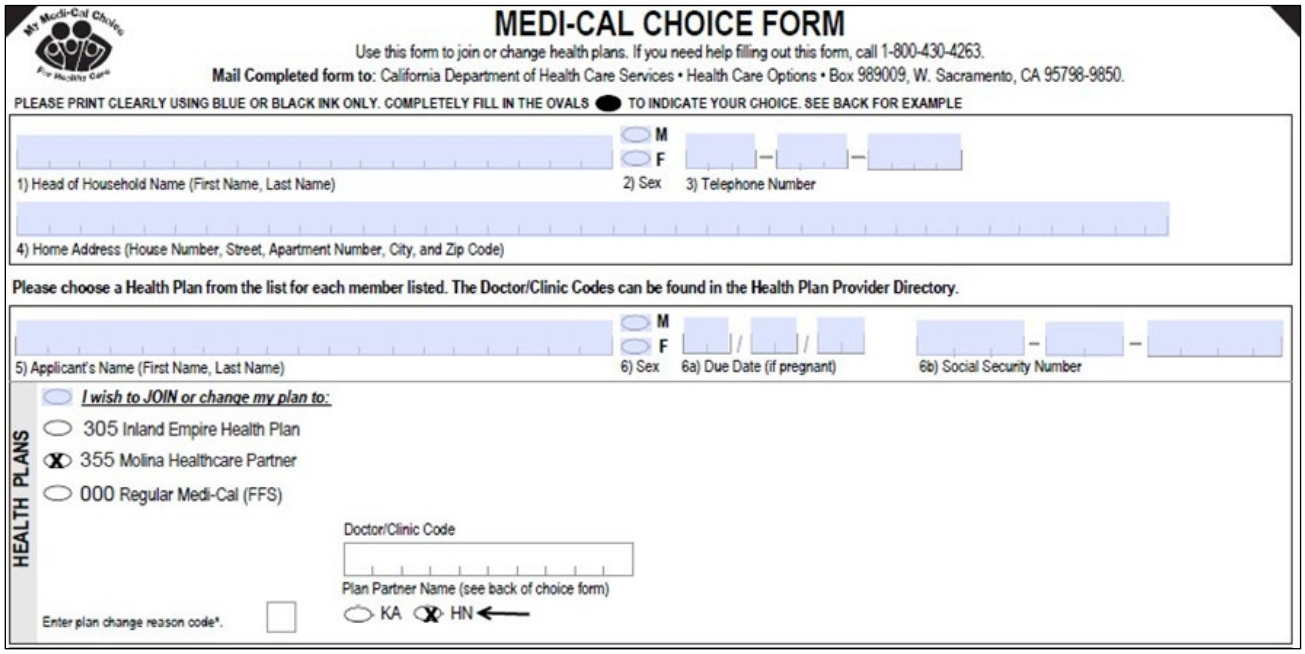
DHCS established the Health Care Options (HCO) referral process to provide Medi-Cal beneficiaries with information on the benefits of receiving health care services through managed care plans and to help the beneficiary choose a managed care plan. The HCO enrollment contractor is also responsible for assigning beneficiaries who do not choose a health plan on the Medi-Cal Choice form. At initial eligibility or annual redetermination, the HCO enrollment contractor sends an enrollment packet to Medi-Cal beneficiaries who do not make a choice at an HCO enrollment contractor presentation. The enrollment packet contains provider directories, a health plan comparison chart, enrollment instructions, a Medi-Cal Choice form, and a Medi-Cal Choice booklet.

## Medi-Cal Choice Form

The beneficiary must select a health plan in his or her designated county and complete and mail back the Medi- Cal Choice form to the HCO enrollment contractor within 30 days of receiving the Medi-Cal Choice form from an HCO enrollment contractor. If the beneficiary does not select a health plan, the HCO enrollment contractor assigns one based on DHCS criteria.

To choose Health Net as a Medi-Cal managed care plan partner in Riverside (355) and San Bernardino (356) counties, Medi-Cal Members must first choose the health plan Molina Health Care Partner and select Plan Partner Name HN.

***Example only:***



MEDI-CAL CHOICE FORM

Use this form to join or change health plans. If you need help filling out this form, call 1-800-430-4263.

Mail Completed form to: California Department of Health Care Services • Health Care Options • Box 989009, W. Sacramento, CA 95798-9850.

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK ONLY. COMPLETELY FILL IN THE OVALS ● TO INDICATE YOUR CHOICE. SEE BACK FOR EXAMPLE

1) Head of Household Name (First Name, Last Name) | 2) Sex M F | 3) Telephone Number

4) Home Address (House Number, Street, Apartment Number, City, and Zip Code)

Please choose a Health Plan from the list for each member listed. The Doctor/Clinic Codes can be found in the Health Plan Provider Directory.

5) Applicant's Name (First Name, Last Name) | 6) Sex M F | 6a) Due Date (if pregnant) | 6b) Social Security Number

HEALTH PLANS

I wish to JOIN or change my plan to:

305 Inland Empire Health Plan

355 Molina Healthcare Partner

000 Regular Medi-Cal (FFS)

Doctor/Clinic Code

Plan Partner Name (see back of choice form)

Enter plan change reason code*.

KA HN

PLAN PARTNER INFORMATION FOR:

305 Inland Empire Health Plan

KA KP Cal, LLC

355 Molina Healthcare Partner

HN Health Net Comm Solutions

## Facility Site Review Compliance Department

The Facility Site Review Compliance Department provides one-to-one education and support.

21281 Burbank Blvd.,
Woodland Hills, CA 91367

Tel: (209) 943-4803
Fax: (877) 779-0753
Facility.site.review@healthnet.com

### Fraud Hotline

Suspected cases of health care fraud and abuse by providers or Members should be reported to the Health Net Fraud Hotline.

Tel: (800) 977-3565

### Health Care Services

The Health Care Services Department conducts concurrent review of inpatient cases and coordinates coverage for patients under the care management program.

Tel: (800) 421-8578
Fax: (800) 743-1655

### Health Education

The Health Education Department improves the health of Medi-Cal Members through education, information and Member support.

650 E. Hospitality Lane, #200
San Bernardino, CA 92407

Tel: (818) 543-9072 or (800) 804-6074
Fax: (800) 628-2704

### Hospital Notification Unit

Hospitals are required to contact the Health Net Hospital Notification Unit within 24 hours or by the end of the next business day when any Health Net Member is admitted to the facility.

Tel: (800) 995-7890
Fax: (800) 676-7969

### Member Appeals and Grievances Contract Relationships

Health Net handles the appeal and grievance process for counties for which Health Net is directly contracted with the Department of Health Care Services (DHCS). Health Net is subcontracted for Medi-Cal business in Riverside and San Bernardino counties and Molina is directly contracted with DHCS. Therefore, Molina processes all appeals and grievances in those counties. Health Net cooperates with Molina by providing information and as described in the contract between Molina and Health Net.

### Mental Health Services MHN Direct Services Care

MHN is Health Net's behavioral health subsidiary. The Customer Service Department is available to providers and their staff, Monday through Friday, 5:00 a.m. to 5:00 p.m., to

assist with the referral process, Member eligibility and benefits, or to schedule a consultation with an MHN medical director/psychiatrist.

## MLTSS (Managed Long-Term Services and Supports)

Managed Long-Term Services and Supports (MLTSS) include a wide variety of services and supports that help Medi-Cal Members meet their daily needs for assistance and improve their quality of life. Medi-Cal MLTSS services are provided over an extended period, and include all of the following Medi-Cal covered benefits:

1. In-Home Support Services
2. Community-Based Adult Services
3. Multipurpose Senior Services Programs and,
4. Skilled Nursing Facility services and subacute services

For members delegated to Health Net in the Inland Empire (Riverside and San Bernardino), Health Net ensures that Members in need of Medi-Cal benefited LTC are placed in facilities that provide the level of care most appropriate to the Member's medical needs. The "facilities" include Skilled Nursing Facilities, Nursing Facilities, Subacute facilities, and Intermediate Care Facilities.

For all questions regarding LTC referrals and authorizations, or the check the status of a request, providers can contact the Health Net Medical Management, Non-Clinical Intake Team at:

Tel: (800) 453-3033
Fax: (855) 851-4563

## Pharmaceutical Services

Health Net's Pharmacy Benefit Manager administers Health Net's Medi-Cal Recommended Drug List (RDL) and medication prior authorization requests.

P.O. Box 419069
Rancho Cordova, CA 95741-9069

Tel: (800) 867-6564
Fax: (800) 977-8226

## Provider Appeals Unit

Submit claims appeals to Health Net Medi-Cal Claims Appeals at the following address:

PO Box 419086
Rancho Cordova, CA 95741-9086

### Provider Network Management

The Provider Network Management Department is the provider liaison to Health Net's administrative programs, including contracting, claims resolution, and on-site education and training.

Tel: (818) 543-9178

### Provider Relations (Riverside and San Bernardino County)

The Provider Relations Department provides support, education and training to Health Net's Medi-Cal provider network.

3131 Camino Del Rio North, Ste. 200
San Diego CA, 92108

Tel: (209) 275-7906
Fax: (866) 660-0464
HN_provider_relations@healthnet.com

### Provider Services Center

The Medi-Cal Provider Services Center handles telephone and written inquiries from providers regarding claims, benefits, and provider grievances and appeals.

21281 Burbank Blvd. C-5,
Woodland Hills, CA 91367

Tel: (800) 675-6110
Fax: (818) 676-5387 or (800) 281-2999

Eligibility and billing inquiries: hnmedi-cal.eligibility@healthnet.com

Claim status and denial inquiries: hnmedi-cal.claimsinquiry@healthnet.com

Capitated claims/nonpayment: hnmedi-cal.providerbilling@healthnet.com

### Public Programs Department

Public programs administrators interact with public health departments and programs and work with participating providers and DHCS in administering public health programs and services.

Tel: (800) 526-1898

## Quality Improvement Department

Contact the State Health Programs Quality Improvement Department for information on quality improvement projects for Health Net's Medi-Cal Members.
Cqi_dsm@healthnet.com

## Transportation (NEMT and NMT)

Transportation services to and from medical appointments for medically necessary covered services are available to all Health Net delegated Medi-Cal Members in Riverside and San Bernardino counties.

## Non-Medical Transportation (NMT)

Effective July 1, 2017, Health Net is providing non-medical transportation (NMT) to and from medical appointments for medically necessary covered services to all its Medi-Cal Members through LogistiCare Solutions, LLC.

## Non-Emergency Medical Transportation (NEMT)

Health Net continues to provide non-emergency medical transportation (NEMT) for Health Net Members assigned to participating physician groups delegated for utilization management but not financially at risk for transportations services.

Any referral source (PPGs, hospitals, skilled nursing facilities, etc.) is required to contact LogistiCare to arrange for transportation services. Using transportation services from any provider other than LogistiCare may result in the denial of the claim for which you may be liable.

A Physician Certification Form (PCS form) is required for both NMT and NEMT services. LogistiCare will send a PCS form to physicians to indicate approval for level of service. Physicians can refer to the table below to contact LogistiCare to obtain a PCS form. For additional information about coverage requirement, refer to the provider operations manuals available in the Provider Library on the Health Net provider website at: provider.healthnet.com

**SCHEDULING TRANSPORTATION SERVICES THROUGH LOGISITCARE**

Providers should refer to the table below and contact LogistiCare to arrange for medically necessary or covered transportation services.

| LogistiCare Transportation Services | |
|---|---|
| LogistiCare uses language-line interpreter services for all interpretation needs during reservations. | |
| **STANDARD DAYS AND HOURS OF CUSTOMER SERVICE CENTER OPERATION FOR ROUTINE RESERVATIONS** | Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific time (PT) |
| **WEEKEND AND HOLIDAY SCHEDULE** | Closed Saturday and Sunday<br>Closed on the following national holidays: New Year's Day, Memorial Day, Independence Day (July 4th), Labor Day, Thanksgiving, and Christmas |
| **ROUTINE TRANSPORTATION REQUESTS** | Requires a 5 business day notification. |
| **URGENT TRIP AND HOSPITAL DISCHARGE REQUESTS** | Advance notice is not required and transportation can be scheduled for the same day of service. For hospital discharge, it may take a transportation provider 1 to 4 hours to pick up a member, depending on provider availability. |
| **HOURS OF OPERATION FOR URGENT AND SAME-DAY RESERVATIONS** | Transportation assistance for trip recovery and after-hours hospital discharges is available 24 hours a day, 7 days a week |
| **HOURS OF OPERATION FOR RIDE ASSISTANCE (*WHERE'S MY RIDE?* LINE) AND HOSPITAL DISCHARGES** | Transportation assistance for trip recovery and after-hours hospital discharges is available 24 hours a day, 7 days a week |
| **ROUTINE TRANSPORTATION APPOINTMENTS SCHEDULED FOR SATURDAY AND SUNDAY AND WEEKDAYS AFTER 5:00 P.M.** | Allowed for regularly scheduled appointments to participating providers who routinely see patients during this time. Reservations for these trips are scheduled during regular reservation hours |
| **TOLL-FREE TELEPHONE NUMBERS** | Reservations: 1-855-253-6863<br>Ride assistance (*Where's My Ride?* line): 1-855-253-6863<br>Hearing impaired (TTY): 1-866-288-3133<br>Facility line: 1-866-529-2128<br>Facility fax: 1-877-601-0535 |
| **WEBSITE** | http://facilityinfo.logisticare.com/cafacility<br>Providers may use the LogistiCare website to schedule only routine transports with advance notice of 5 business days. Print an enrollment form from the LogistiCare website to sign up for this HIPAA-compliant service and return by fax to 1-877-601-0535 |

## Vision

Health Net has partnered with Evolve Vision to provide vision services to Health Net Members. The PCP is the primary screener for ocular abnormalities requiring referral for a comprehensive eye examination.

Comprehensive eye examinations performed by an optometrist or ophthalmologist are covered for all Medi-Cal Members. Providers should refer to the Health Net Provider Directory for a list of participating optometrists and ophthalmologists. Providers should contact the Health Net Medi-Cal Provider Services Center to obtain the most current directory.

For Health Net Delegated Members, Optical lenses are made by California Prison Industry Authority (CalPIA) optical laboratories and provided with cost through the optometrist's or ophthalmologist's office participating with Evolve Vision for covered vision services.

# CONTACTS: RIVERSIDE COUNTY

### Molina Healthcare of California
### San Bernardino/Riverside Regional Office

Tel: (800) 232-9998

Send correspondence to:

550 E. Hospitality Ln. Ste. 100
San Bernardino, CA 92408

Attn: Provider Services

### Child Health and Disability Prevention (CHDP) Program

10769 Hole Ave., Suite 210
Riverside, CA 92505

Tel: (951) 358-5481
Fax: (951) 358-5002

PM 160 County Code: 355

Mail:

PO Box 7600
Riverside, CA 92513- 7600

### Communicable Disease Control

Tel: (951) 358-5107

### CPSP Perinatal Services

308 E. San Jacinto Ave.
Perris, CA 92570

Tel: (951) 210-1480
Fax: (951) 306-3760

### Regional Center

(Riverside and San Bernardino County)
Inland Regional Center
1365 S. Waterman Ave.
San Bernardino, CA 92408

Mail:

PO Box 19037
San Bernardino, CA 92423

Tel: (909) 890-3000

### Riverside University Health System

4065 County Circle Drive
Riverside, CA 92503

Tel: (951) 358-5000

### Riverside University Health System- Behavioral Health

CARES (Community Access, Referral,
Evaluation, and Support) Line

Tel: (800) 706-7500
Hearing Impaired (TTY/TDD): (800) 915-5512

### Riverside University Health System Substance Abuse

CARES (Community Access, Referral, Evaluation, and Support) Line
Tel: (800) 499-3008

### TB Control Program

Disease Control Branch
Health Administration Building
4065 County Circle Drive
Riverside, CA 92503

Tel: (951) 358-5107

### Women, Infant, & Children (WIC)

Banning Tel: (800) 732-8805
Riverside Tel: (800) 455-4942

# CONTACTS: SACRAMENTO COUNTY

### Molina Healthcare of California
### Northern Regional Administration Office

Send correspondence to:
200 Oceangate Suite 100
Long Beach, CA 90802Attn: Provider Services

Tel: (855) 322-4075

### RX Staffing Aids Project

4640 Marconi Avenue, Suite 1
Sacramento, CA 95821-4316

Tel: (916) 979-7300

### Alcohol and Drug Treatment Services

Alcohol and Drug System of Care
Tel: (916) 874-9754

The last assessment is conducted at 4:00 p.m.

### Child Health and Disability Prevention (CHDP) Program

County Department of Health
9616 Micron Avenue, Suite 670
Sacramento, CA. 95827

Tel: (916) 875-7151
Fax: (916) 875-9773

PM 160 County Code: 130

### Sacramento County Public Health/Perinatal Services

9616 Micron Ave. Suite 670
Sacramento, CA 95827

Tel: (916) 876-7750

### Sacramento County Division of Public Health

7001-A East Parkway, Suite 600A
Sacramento, CA 95823

Tel: (916) 875-5881

### Sacramento County Sexual Health Promotion Unit

Tel: (916) 875-6022

### Regional Center

Alta California Regional Center
2241 Harvard Street, Suite 100
Sacramento, CA 95815

Tel: (916) 978-6400

### Sacramento County Behavioral Health Services

Grantland L. Johnson Center for Health and Human Services
7001-A East Parkway, Suite 400
Sacramento, CA 95823

Tel: (916) 875-7070
Fax: (916) 875-6970

Email: hhs-bhs@saccounty.net

Mental Health Access Team
Tel: (916) 875-1055 or toll free (888) 881-4881

### Sacramento County Public Health

7001 East Parkway, Suite 400
Sacramento, CA 95823

Tel: (916) 875-5881
Fax: (916) 854-9709 (CMR's patient files and reports)

### Women, Infants and Children (WIC)

2251 Florin Road #100
Sacramento, CA. 95822

Tel: (916) 876-5000

## TB Control Program

Primary Care Center, Chest Clinic
4600 Broadway
Sacramento, CA 95820

Tel: (916) 874-9670

# CONTACTS: SAN BERNARDINO COUNTY

### Molina Healthcare of California
### San Bernardino/Riverside Regional Office

Send correspondence to:

550 E. Hospitality Ln. Ste. 100
San Bernardino, CA 92408

Attn: Provider Services

Tel: (800) 232-9998

### Calif. Children's Services (CCS) Program

150 E Holt Blvd, 3rd Floor
Ontario, CA 91762

Tel: (909) 458-1637
Fax: (909) 986-2970

Email: ccs@dph.sbcounty.gov

### Child Health and Disability Prevention (CHDP) Program

606 East Mill Street., 2nd floor
San Bernardino CA 92415

Tel: (909) 383-3022 or (800) 722-3777
Fax: (909) 383-3023

PM 160 County Code: 356

### Communicable Disease Control

351 N. Mountain View Avenue
San Bernardino, CA 92415

Tel: (800) 722-4794
Fax: (909) 387-6377

### CPSP Perinatal Services

606 East Mill St.
San Bernardino, CA 92415-0011

Tel: (909) 383-3022 or (800) 227-3034
Fax: (909) 383-3023

### San Bernardino County Public Health

351 N. Mt. View Avenue
San Bernardino, CA 92415

Tel: (800) 782-4264
Hearing Impaired (TTY/TDD): (909) 387-6359

### San Bernardino County Behavioral Health

303 E. Vanderbilt Way
San Bernardino, CA 92415

Member Services: 24/7

Access & Referral Helpline:

Tel: (888) 743-1478 or (909) 386-8256

### San Bernardino County Behavioral Health

Substance Use Disorder & Recovery

Tel: (909) 386-9740 or (800) 968-2636 Toll Free
Fax: (909) 387-7717

### Women, Infant, & Children (WIC)

San Bernardino Tel: (855) 424-7942

# CONTACTS: SAN DIEGO COUNTY

### Molina Healthcare of California
### San Diego Regional Office

Send correspondence to:

9275 Sky Park Ct, Suite 190
San Diego, CA 92123

Attn: Provider Services

Tel: (858) 614-1580

### AIDS Waiver Agency

150 Valpreda Road, Suite 211
San Marcos, CA 92069

Tel: (760) 736-6725

### Calif. Children's Services (CCS) Program County Department of Health

6160 Mission Gorge Road Ste. 400
San Diego, CA 92120

Tel: (619) 528-4000
Fax: (858) 514-6514

### Child Health and Disability Prevention (CHDP) Program

3851 Rosecrans Street
San Diego, CA 92110

Tel: (619) 692-8808
Fax: (619) 399-3759

PM 160 County Code: 013

Mail:

PO Box 85222,
San Diego, CA 92186-5222

### Communicable Disease Control

Tel: (619) 692-8499 or (858) 565-5255 (urgent matters, evenings, weekends, and holidays only)

### CPSP Perinatal Services

3851 Rosecrans Street, Suite 522
San Diego, CA 92110

Tel: (619) 542-4053
Fax: (619) 542-4045

### Regional Center

4355 Ruffin Road, Suite 200
San Diego, CA 92123-1648

Tel: (858) 576-2996

### San Diego Behavioral Health Services Health and Human Services Agency

3255 Camino del Rio
San Diego, CA 92108

Tel: (619) 563-2700

### San Diego County Public Health

Tel: (619) 229-5400

### Substance Use Disorder Services

Alcohol and Drug Services
Tel: (888) 724-7240

### TB Control Program

Tel: (619) 692-5565

### Women, Infant, & Children (WIC)

Chula Vista Tel: (619) 426-7966
San Diego Tel: (800) 500-6411
San Marcos Tel: (760) 471-2743
SDSU Tel: (888) 999-6897

# 2. ELIGIBILITY, ENROLLMENT, DISENROLLMENT

## ELIGIBILITY FOR MANAGED CARE

### Mandatory Aid Categories

Under the Geographic Managed Care (GMC) and Two-Plan Model, enrollment is mandatory for the following aid categories eligible for Medi-Cal without a share-of-cost:

- CalWorks - formerly Aid to Families with Dependent Children (AFDC)
- CalWorks - formerly Medically Needy, Family (AFDC)
- Medically Indigent Children
- Refugee/Entrant
- Public Assistance, Family

### Voluntary Aid Categories

Beneficiaries who fall into these aid categories may enroll but are not required to do so:

- Public Assistance, Aged
- Public Assistance, Blind/Disabled
- Medically Needy, Aged (no share-of-cost)
- Medically Needy, Blind/Disabled (no share-of-cost)
- Medically Indigent Adult

### Exemptions from Mandatory Enrollment

Medi-Cal beneficiaries meeting the following criteria are exempt from mandatory enrollment:

- Individuals with a complex or high-risk medical condition who are in an established treatment relationship with a provider(s)/practitioner(s) or who are not participating in the GMC or Two-Plan Model provider/practitioner network
- Children in Foster Care or the Adoptions Assistance Program*
- Native Americans, their household members, and other persons who qualify for services from an Indian Health Center*

### Not Permitted to Enroll

Medi-Cal beneficiaries meeting the following criteria are not permitted to enroll under the GMC Program and Two-Plan Model:

- Individuals with the following other health coverage:
  - Kaiser HMO
  - CHAMPUS
  - Other HMO coded K, F, C, or P

- Medicare HMO (unless it is also a Geographic Managed Care Plan, and the Department of Health Care Services allows this plan to enroll beneficiaries in both the contractor's Medicare HMO and Medi-Cal managed care plan)

* These individuals are exempt from mandatory enrollment, although if they wish to enroll, they may do so.

## New Members

Molina Healthcare of California (MHC) receives EDI 834 Benefit Enrollment and Maintenance transactions from DHCS and weekly Health Care Options (HCO) data file. The data received from HCO is matched to the processed EDI 834 and stored in MHC's core operating system. This process creates a new Member file for eligibility purposes and production of Member identification cards. Each new Member receives an MHC Welcome Packet that includes an MHC identification card. This identification card will contain the name of the Member's Primary Care Practitioner (PCP). To identify a Member's assigned PCP, you may also refer to MHC's Interactive Voice Response system or the Plan's Member Services Department. The identification card issued by MHC is for Plan Identification only. Although the Member eligibility is verified at the time the card is issued, possession of the card does not guarantee eligibility. In case a Member has lost the identification card or his/her eligibility is in question, eligibility may be verified using one of the following options:

- Availity Essentials portal: provider.MolinaHealthcare.com
- IPA/Medical Group Eligibility List file Molina Healthcare Interactive Voice Response at (888) 665-4621 MHC's Member Services department at (888) 665- 4621

If the Member does not appear on the current eligibility roster, the Provider/Practitioner should contact MHC's Provider Services department at (855) 322-4075.

At no time should a Member be denied services because his/her name does not appear on the eligibility roster. Please remember that a Member may access emergency services without prior authorization.

Remember, the card is for identification purposes only. Eligibility to receive services depends on verification from MHC. If a Member has questions that you are unable to answer, suggest a call to MHC's Member Services department.

## Eligibility Verification

Providers are encouraged to register and use the Molina's Provider Web-Portal as a primary method to check Member's eligibility information: www.MolinaHealthcare.com.

The MHC Interactive Voice Response (IVR) system notifies both Providers/Practitioners and Members of Member eligibility status and PCP assignment. The system has a dedicated phone line at (800) 357-0172 and is available 24 hours a day, 365 days a year. The system provides Members' last name, first name, date of birth, eligibility

status, and PCP information, as well as IPA/Medical Group affiliation and subcontract health plan affiliation as applicable.

In the event that the IVR System is not working, Provider/Practitioner may verify eligibility directly with Molina's Member Services representative (888) 665-4621 from Monday through Friday, 7:00 a.m. to 7:00 p.m. Any calls made during non-business hours go directly to MHC's after hour service, with the same access to current Member eligibility status.

### Eligibility List Files

MHC distributes Eligibility reports monthly to provide information on Member enrollment in an IPA/Medical Group. The reports are generated the first week of each month and mid-month MHC Medi-Cal Members who have changed Providers/Practitioners by the 15th of a month will be in effect for the currently calendar month. Members who have changed Providers/Practitioners on or after the 16th of a month will be in effect the first day of the listed on the month following the next month

These files are secured, and password protected and can only be accessed by the IPA/Medical group designee that are identified as the recipient. For additional details of the IPA/Medical Group Eligibility List files, please contact your Provider Services representative.

If a Member arrives at a PCP's office to receive care, please verify the Member's eligibility through Molina's Provider Web-Portal, Eligibility List file or MHC Member Services. A Member must not be denied services because his/her name does not appear on the eligibility roster.

## Medi-Cal Enrollment

Health Care Options (HCO) is responsible for providing Medi-Cal beneficiaries information pertaining to the benefits of health care services through a managed care plan. HCO also assists the beneficiary in making choice among the different managed care plans. HCO is responsible for assigning beneficiaries who fail to choose a health plan to a managed care plan within each beneficiary's county. HCO is responsible for the distribution of enrollment forms to beneficiaries as well as to the various managed care health plans. The health plans then distribute the forms to their prospective Members upon request. The health plans and their affiliated Providers/Practitioners are no longer allowed to submit the Medi-Cal Enrollment Forms on behalf of their patients. If beneficiaries have questions regarding the enrollment process, they should be directly referred to HCO at (800) 430-4263 Please visit DHCS website at: www.DHCS.ca.gov for additional information on Medi- Cal Enrollment.

## PCP Auto Assignment

Upon initial enrollment, if the Member did not select a PCP, MHC will assign a PCP to the Member and mail out an ID card with the Welcome Packet indicating PCP

assignment. The Welcome letter explains to the Member that they may select a different PCP if they are dissatisfied with the choice made for them. The letter also advises Members of the importance of scheduling an appointment with their PCP within the first 90 days of initial enrollment.

The following criterion is followed when processing auto assignment of a PCP:

- The proximity of the provider/practitioner must be within 10 miles or 30 minutes of Member's residence
- The Member's language preference
- The Member's age, gender, and special PCP needs (i.e., Pediatrician, Obstetrician, etc.)
- The existence of established relationships and family linkages
- MHC makes every attempt to assign Members to the PCP of their choice. MHC is limited to the information that is on the HCO data file, which is neither always complete nor correct

## Disenrollment Process

Any Member of MHC may at any time, without cause, request to be disenrolled from the plan. The Member must contact HCO at (800) 430-4263. An HCO representative will mail a disenrollment form to the Member's residence. A Member with a mandatory aid code must simultaneously re-enroll into another managed care health plan. If the Member fails to select a health plan, HCO will automatically assign him/her to one. Members who have a voluntary aid code may elect to remain in the Medi-Cal Fee-for-Service program or select a new health plan.

Until the Member's disenrollment request is approved and processed by DHCS, MHC will be responsible for the Member's health care.

Disenrollment of a Member is mandatory under the following conditions:

- Member requests to be disenrolled
- Member loses Medi-Cal eligibility
- Member moves out of the Plan's approved service area
- Member's Medi-Cal aid code changes to an aid code not covered
- Member's enrollment violates the State's marketing and enrollment regulations
- Member requests disenrollment as a result of a Plan merger or reorganization
- Member is eligible for those carve-out services that require disenrollment. (See Additional Services or Carve-Out Services)

Members disenrolled because of any of the above conditions will be allowed to return to the Fee-for-Service Medi-Cal Program unless their Medi-Cal eligibility is a mandatory managed care aid code or eligibility is terminated by DHCS. MHC does not determine eligibility for the Medi-Cal program. DHCS allows for certain beneficiaries to remain in Fee-for-Service Medi-Cal as described above, under the Heading, Exemptions from

Mandatory Enrollment. Such exemptions are granted by HCO and DHCS, not MHC. For more information, contact HCO at (800) 430-4263.

A Provider/Practitioner may request to DHCS that a Plan Initiated Disenrollment (PID) be processed for any of its Members. However, the health plan is responsible to initiate the process with DHCS. All written communication letters sent to the Members must be prior approved by the Plan and/or DHCS.

The Provider/Practitioner contracted with MHC must make its requests in writing and forward such requests to MHC's Member Services Department, Attn: Member Services Director. These requests must include a detailed description of the circumstances prompting the Provider/Practitioner to initiate the request for disenrollment.

Included should be any documentation and detailed description of corrective action taken by the Provider/Practitioner in an effort to resolve the matter. The detailed description should include:

- Statement of the specific issue
- Dates of occurrence
- Frequency of occurrence

Upon receipt of such request from the Provider/Practitioner, the Member Services Department Director or designee will make an effort to contact the Member to provide education and counseling. Member Services will involve a Case Manager to attempt to coordinate care. The Member may be transferred to another PCP within the plan. In every case, the Member is notified in writing of the intent to disenroll and given a 30-day opportunity to appeal to the Member Services Department or DHCS fair hearing via telephone or in writing. At no time should the Provider/Practitioner contact the Member without approval of the Member Services Department Director or designee. The Member Services Department Director or designee will then review the request with the Plan's Medical Director and process a PID request to DHCS for approval. Once DHCS reviews the request; the Member is mailed a letter, via U.S. mail, notifying him/her of the outcome.

MHC is responsible to notify the Member via certified mail that the Plan has been notified of their behavior. The Member will be warned that further non-compliance may result in transferring the Member to an alternate Provider/Practitioner or termination of membership from the plan based on the severity of the issue. If the Member fails to comply and behavior is repeated, the Provider/Practitioner must immediately send documentation of repeated offense to MHC Member Services. The Provider/Practitioner is responsible for sending final documentation to the Plan. MHC must notify the Member again (second and final notification) in writing via U.S. certified mail of MHC's intent to request a PID or transfer to an alternate Provider/Practitioner. The provider will receive a copy of the letter for their medical records.

A PID is evaluated on the severity and cause of the breakdown of the Provider/Practitioner/Member relationship. Below are examples of circumstances that

could result in a PID. To initiate a PID, the documentation process outlined above must be followed.

DHCS will approve a request only if one or more of the following circumstances have occurred:

- The Member is repeatedly verbally abusive to Plan Providers/Practitioners, ancillary or administrative staff, or to other Plan Members
- The Member physically assaults a Plan Provider/Practitioner, staff member, or Plan member, or the Member threatens any individual with any type of weapon on the Plan premises. In such cases, appropriate charges must be brought against the Member, and a copy of the police report should be submitted along with the request
- The Member is disruptive to Provider/Practitioner operations in general with potential limitation of access to care by other patients
- The Member habitually uses non-contracted Providers/Practitioners for non-emergency services without prior authorization
- The Member has allowed the fraudulent use of his or her health plan identification card
- The Member refuses to transfer from a non-Plan hospital to a Plan hospital when it is medically safe to do so
- Other inappropriate use of out-of-plan services that result in degradation in the Plan's relations with community Providers/Practitioners thereby threatening the access of other Plan Members

A Member's failure to follow prescribed medical care treatment, including failure to keep established medical appointments, does not warrant a request for a PID unless MHC can demonstrate to DHCS that, as a result of such failure, the Plan or Provider/Practitioner is exposed to greater and unforeseeable risk. In this event, a temporary PID may be requested by the Plan and granted by DHCS.

## Expedited Disenrollment Requests

The Plan may request for an expedited disenrollment for the following:

- Continuity of Care - If the treating Provider/Practitioner is not part of MHC's network of Providers/Practitioners, the Member may be eligible for disenrollment. The Member is only eligible for disenrollment within the first 90 days of initial enrollment with MHC. A medical exemption form signed by the treating Provider/Practitioner and Member is required for processing
- Incarceration - The name of the facility and the date the Member entered the facility is required for processing
- Resides Outside-of-the-Service Area - The Member moved outside of the service area. The Member's new address and move date is required. The Member must report their change of address to their eligibility worker within 10 days. Failing to do so will result in delaying the disenrollment from MHC
- Native American - If the Member is a Native American the Member may be exempted from being in a health plan. A Non-Medical Exemption form must be

completed by an Indian Health Service Provider/Practitioner. The form is required for processing

All requests for expedited disenrollment's along with any required documentation must be submitted to Enrollment Supervisor via facsimile at (855) 248-7534 or US Mail. The Member may also initiate a request by calling Member Services department at (888) 665-4621. If you need copies of the exemption forms mentioned, please contact HCO at (800) 430-4263.

Molina Healthcare
Attn: Enrollment Supervisor
200 Oceangate, Suite 100
Long Beach, CA 90802

Fax: (855) 248-7534

Related Policies- For more information or a copy of the complete PID policy, contact MHC's Member Services department at (888) 665-4621.

# 3. BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and Covered Services for Molina Medi-Cal Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization. please reference the Prior Authorization tools located at on the Molina website and Availity Essentials portal: provider.MolinaHealthcare.com.

You may also please contact Molina at 888-665-4621 (Monday-Friday, 7a.m. to 6p.m.).

## Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that Members must pay for Covered Services provided under their Molina plan. The Cost Sharing amount Members will be required to pay for each type of Covered Service is summarized on the Member's ID card.

It is the Provider's responsibility to collect the copayment and other Member Cost Share from the Member to receive full reimbursement for a service. The amount of the copayment and other Cost Share will be deducted from the Molina payment for all Claims involving Cost Share.

## Service Covered by Molina

Molina covers the services described in the Summary of Benefits documentation. If there are questions as to whether a service is covered or requires prior authorization, please reference the Prior Authorization tools located at on the Molina website and the provider.MolinaHealthcare.com Availity Essentials portal: provider.MolinaHealthcare.com

### Obtaining Access to Certain Covered Services

### Non-Preferred Drug Exception Request Process

The Provider may request a prior authorization for clinically appropriate drugs that are not preferred under the Member's Medicaid Plan. Using the FDA label, community standards, and high levels of published clinical evidence, clinical criteria are applied to requests for medications requiring prior authorization.

- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within 24 hours of receiving the complete request.
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within 24 hours of receiving the complete request.
- Molina will allow a 72-hour emergency supply of prescribed medication for dispensing at any time that a prior authorization is not available. Pharmacists will use their professional judgment regarding whether or not there is an immediate need

every time the 72-hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

### Specialty Drug Services

Many self-administered and office-administered injectable products require prior authorization. In some cases, they will be made available through a vendor, designated by Molina. More information about our prior authorization process, including a link to the Prior Authorization Request Form, is available in the Healthcare Services section of this Manual. Physician administered drugs require the appropriate National Drug Code (NDC) with the exception of vaccinations or other drugs as specified by CMS.

### Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor, designated by Molina. More information about our Prior Authorization process, including a link to the PA request form, is available in the Pharmacy section of this Provider Manual.

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

### Access to Behavioral Health Services

Members in need of access to Behavioral Services is available through PCP referral for services or Members can self-refer by calling Molina's Member Contact Center at (888) 665-4621. Molina's Nurse Advice Line is available 24 hours a day, seven days a week, 365 days per year for mental health or substance use disorder needs. The services Members receive will be confidential.

Additional detail regarding Covered Services and any limitations can be obtained in the benefit information linked above, or by contacting Molina.

### Emergency Mental Health or Substance Abuse Services

Members are directed to call 988, 911 or go to the nearest emergency room if they need Emergency Services mental health or substance abuse. Examples of emergency mental health or substance abuse problems are:

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

## Out of Area Emergencies

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

- Go to the nearest emergency room
- Call the number on ID card
- Call Member's PCP and follow-up within 24 to 48 hours

For out-of-area Emergency Services, plans will be made to transfer Members to an in-network facility when Member is stable.

## Emergency Transportation

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

## Non-Emergency Medical Transportation

For Molina Medi-Cal Members who have non-emergency medical transportation as a Covered Service, Molina covers transportation to medical facilities when the Member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, etc.). This requires a written prescription from the Member's doctor. Examples of non-emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. Members must have Prior Authorization from Molina for air ambulance/transportation services before the services are given. Prior Authorization is not required for vans, taxi, etc. Additional information regarding the availability of this benefit is available by contacting Provider Services.

Transportation coverage is also limited to the nearest Provider/Practitioner capable of meeting the needs of the Member. Providers/Practitioners must submit the Physician Certification Statement (PCS) form to the plan in order for NEMT transportation to be provided, in accordance with DHCS guidelines. The PCS form must be completed in its entirety, and include the following elements:

- Function Limitations Justification: Document the Member's limitations and provide specific physical and medical limitations that preclude the Member's ability to reasonably ambulate without assistance or be transported by public or private vehicles
- Dates of Service Needed: Provide start and end dates for NEMT services; for a maximum of 12 months
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport)
- Certification Statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested

**NEMT Modes of Transport and Criteria**

| Mode of Transport | Criteria |
|---|---|
| Ambulance | • Transfers between facilities for Members who require continuous intravenous medication, medical monitoring, or observation<br>• Transfers from an acute care facility to another acute care facility<br>• Transport for Members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use)<br>• Transport for Members with chronic conditions who require oxygen if monitoring is required |
| Litter Van: When the Member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following | • Requires that the Member be transported in a prone or supine position, because the Member is incapable of sitting for the period of time needed to transport<br>• Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance |
| Wheelchair Van: When the Member's medical and physical condition does not meet the need for litter van services, but meets any of the following | • Renders the Member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport<br>• Requires that the Member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation<br>• Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance<br>• Members with the following conditions qualify for wheelchair van transport: Members who suffer from severe mental confusion |

| Mode of Transport | Criteria |
|---|---|
| | • Members with paraplegia; Dialysis recipients; Members with chronic conditions who require oxygen but do not require monitoring |
| Air transport: Only provided under the following conditions | • When transportation by air is necessarybecause of the Member's medical condition or because practical considerations render ground transportation not feasible |

**Non-Emergency Non-Medical Transportation (NMT)**

Non-Emergency non-medical transportation (NMT) is available to Member when used to obtain medically necessary services. They must have no other form of transportation available. NMT does not include transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with State and local statutes, ordinances, or regulations.

Molina provides the following NMT services:

- Round-trip transportation for a member by passenger car, taxicab, bus, train, or any other form of public or private conveyance (including a private vehicle). NMT also includes mileage reimbursement for medical purposes when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

Round-trip NMT is available for the following:

- Members picking up drug prescriptions that cannot be mailed directly to the member.
- Members picking up medical supplies including prosthetics, orthotics, or other equipment
- Other medically necessary services

NMT transportation to medical services can be supplied by a passenger car, taxi cabs, or other forms of public/private transportation. Transportation must be arranged at least three working days before appointment.

Additional information regarding the Transportation benefit is available by contacting Provider Services at (888) 562-5442.

## Preventive Care

Preventive Care Guidelines are located on the Molina website. Please use the link below to access the most current guidelines.

https://www.molinahealthcare.com/providers/ca/medicaid/resource/guide_prevent.aspx

We need your help conducting these regular exams in order to meet the targeted State and Federal standards. If you have questions or suggestions related to preventive care guidelines, please contact Quality at (800) 526-8196 ext. 126137.

## Immunizations

Adult Members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the Member's PCP. Child Members may receive immunizations in accordance with the recommendations of the American Academy of Pediatrics (AAP) and prescribed by the child's PCP.

Immunization schedule recommendations from the American Academy of Pediatrics and/or the CDC are available at the following website:
https://www.cdc.gov/vaccines/schedules/hcp/index.html

If a pediatric immunization is medically necessary, and not covered under the federal/state Vaccines for Children (VFC) VFC: Vaccines for Children Program | CDC program, Molina would cover that immunization with a prior authorization request.

## Well Child Visits and EPSDT Guidelines

The Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well care examinations to individuals from birth until 21 years of age, with diagnosis and treatment of any health or mental health problems identified during these exams. The standards and periodicity schedule generally follow the recommendations from the American Academy of Pediatrics (AAP) and its Bright Futures guidelines.

The screening services include:

- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- Immunizations in accordance with the most current AAP, California and federal (Centers for Disease Control and Prevention Advisory Committee on Immunization Practices) Childhood Immunization Schedule, as appropriate
- Comprehensive unclothed physical exam
- Laboratory tests as specified by the AAP, including screening for lead poisoning
- Health education
- Vision services
- Hearing services
- Dental services

When a screening examination indicates the need for further evaluation, providers must provide diagnostic services or refer members for such services when appropriate without delay. Providers must provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services.

If you take care of our pediatric members, we need your help conducting these regular exams in order to meet the California Department of Health Care Services requirements. We also want to ensure our children get access to these important benefits. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well childcare, please contact our Quality team at (800) 526-8196 ext. 126137.

## Prenatal Care

| Stage of Pregnancy | How Often to see the doctor |
|---|---|
| 1 month – 6 months | 1 visit a month |
| 7 months – 8 months | 2 visits a month |
| 9 months | 1 visit a week |

## Emergency Services

Emergency Services means: Emergency Services are covered inpatient and outpatient services provided to address an Emergency Medical Condition that are furnished by a provider qualified to furnish emergency services and are needed to evaluate or stabilize an Emergency Medical Condition. Emergency Services include ambulance services dispatched through 911 or local equivalents. Emergency Services are those services that are urgently needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition or Emergency means: 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: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of any bodily organ or part, or (d) serious disfigurement.

Emergent and urgent care Services are covered by Molina without an authorization. This includes non- contracted Providers inside or outside of Molina's service area.

## Nurse Advice Line

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

English Phone: (888) 275-8750
Spanish Phone: (866) 648-3537
Hearing Impaired: (TTY/TDD) 711

Molina is committed to helping our Members:

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

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

### Health Management Programs

For additional information, please refer to the Benefits and Covered Services: Health Education section of this Provider Manual.

### Telehealth and Telemedicine Services

Molina Members may obtain physical and behavioral health Covered Services by 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
- Members have the option of receiving PCP services through telehealth. If they choose to use this option, the Member must use a Network Provider who offers telehealth
- 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
- Rendering Provider must comply with applicable federal and state guidelines for telehealth service delivery

Ensure records are entered into a patient record system shared with the members primary care provider or are otherwise provided to the members primary care provider, unless the member objects, in a manner consistent with the state and federal law.

“Third-party corporate telehealth provider” means a corporation directly contracted with a health care service plan that provides health care services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services.

Third party corporate telehealth providers to obtain enrollee consent to receive the service via telehealth through a third-party corporate telehealth provider consistent with Business and Professions Code Section 2290.5.

Third party corporate telehealth providers are required to submit reporting data as requested and specified by Molina.

For additional information on Telehealth and Telemedicine Claims and billing, please refer to the Claims and Compensation section of this Provider Manual.

# 4. BENEFITS AND COVERED SERVICES: HEALTH EDUCATION

## Molina Healthcare Health Education

Phone: (866) 891-2320 (Monday to Friday, 8:30A.M. to 5:30P.M.)
Fax: (800) 642-3691
Email: HealthEducation.MHC@MolinaHealthcare.com

The provision of health education services is the responsibility of IPA affiliated medical groups under the Managed Medi-Cal contract. As Providers/Practitioners, you are in the best position to meet the many educational needs of MHC Members at the time of their medical visits. You are the most credible educator for your patients. However, MHC supports our providers/practitioners by making available many Health Education programs, materials and services that will be discussed below.

## DHCS Health Education Contract Requirements for Managed Medi-Cal Members

To meet DHCS Managed Medi-Cal contract requirements for health education services, IPAs/Providers must make available to Members educational services in the following areas:

- **Appropriate use of health care services** – Use of managed healthcare services; screenings and immunizations
- **Risk–reduction and healthy lifestyles** – Nutrition, behavioral health management, fitness, dental, flu prevention, sexually transmitted infections, complementary and alternative therapies
- **Self-care and management of health conditions** – Diabetes, cancer, pregnancy, asthma and COPD, cardiovascular disease, renal disease, postpartum, caring for your new baby, senior health and others

All education must be documented in the Member's medical record. This information should become part of the Member's ongoing medical care as all team Members can reinforce new positive health behaviors. This documentation also becomes critical in the event of an audit by any regulatory organization.

## Tobacco Prevention and Cessation Services

All providers are required to identify and track all tobacco use, both initially and annually. This must be performed by doing the following:

- Completing the individual Health Assessment, which includes the Individual Health Education Behavioral Assessment (IHEBA), for all new beneficiaries within 120 days of enrollment
- Annually assess tobacco use status for every beneficiary based on the SHA's periodicity schedule

- Ask tobacco users about their current tobacco use and document in their medical record at every visit
- Advise every patient to quit using tobacco products
- Refer patient to Kick It California at (800) 300-8086

More information on the IHEBA and SHA can be found in the "Healthcare Services: Women's & Adult Health Services, Including Preventive Care" section of the manual.

All providers are also required to institute a tobacco user identification system to identify tobacco users in their primary care practice, per USPSTF recommendations. Among other things, a tobacco user identification system for providers may include:

- Adding tobacco use as a vital sign in the chart or Electronic Health Records
- Using International Classification of Diseases (ICD)-10 codes in the medical record to record tobacco use
  - The ICD-10 code for vaping related disorder is U07.0 and for Smoking is Z72.0
- Placing a chart stamp or sticker on the chart when the beneficiary indicates he or she uses tobacco
- A recording in the SHA or other IHEBA
- A recording on the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM 160)
- Reviewing Nicotine Replacement Therapy (NRT) claims

It is the intent of this requirement that providers not only assess tobacco use but report it to Molina, in order to more fully coordinate Molina Members' tobacco cessation treatment.

### Services for Pregnant Tobacco Users

Because of the serious risk of smoking to the pregnant smoker and fetus, whenever possible, pregnant beneficiaries should be offered tailored, one-on-one counseling exceeding minimal advice to quit.

Providers are required to:

- Ask all pregnant beneficiaries if they use tobacco or are exposed to tobacco smoke
- Offer all pregnant beneficiaries who use tobacco at least one face-to-face tobacco cessation counseling session per quit attempt
- Refer pregnant beneficiaries who use tobacco to a tobacco cessation quit line, such as the California Smoker's Helpline
- Refer to the tobacco cessation guidelines by the American College of Obstetrics and Gynecology (ACOG) before prescribing tobacco cessation medications during pregnancy

### Prevention of Tobacco Use in Children and Adolescents

Providers are required to:

- Provide interventions, including education or counseling, in an attempt to prevent initiation of tobacco use in school-aged children and adolescents. Services shall be provided in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance, as periodically updated

### Provider Training

Providers are strongly encouraged to refer to the "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update" for provider training on tobacco cessation treatments. This document informs and educates clinicians regarding effective strategies and approaches for providing tobacco cessation treatment for all populations, including specific recommendations for pregnant women.

When counseling beneficiaries, providers are encouraged to use the "5 A's" (Ask, Advise, Assess, Assist, and Arrange), the "5 R's" (Relevance, Risks, Rewards, Roadblocks, Repetition), or other validated behavior change models.

Please refer to the below links for more information on the "5 A's" and "5 R's":

http://www.improvingchroniccare.org/downloads/3.5_5_as_behaviior_change_model.pdf

or

http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5rs.html

## Special Programs Provided by Molina Healthcare

To support our provider network, MHC makes available programs and services in many of the required areas. If you are an IPA/Medical Group affiliated Provider/Practitioner, please consult the table titled "Health Education Services" in the exhibit section to determine the remaining requirements that are your responsibility.

### Health Management Programs

Molina's Health Management programs provide patient education information to Members and helps facilitate Provider access to these chronic disease programs and services. Health Management staff; Registered Nurse, Registered Dietitian, Licensed Vocational Nurse, Social Worker, and or Health Educator are available telephonically to share information about Molina Programs. They will assist Members with preventative education and management of their conditions. They will collaborate with the Member and Provider relating to specific needs identified for best practices. Molina requests that you as a Provider also help us identify Members who may benefit from these programs.

Members can request to be enrolled or dis-enrolled in these programs. These include programs, such as:

- Asthma (Breath with Ease Asthma Program)
- Depression (Building Brighter Days Adult Depression Management Program)
- Weight Management
- Smoking Cessation (Kick It California)
- Diabetes Prevention Program

To find out more information about the health management programs, please call Provider Services department at (855) 322-4075.

## Breathe with Ease℠ Program

Molina Healthcare provides an asthma health management program called breathe with ease℠, designed to assist Members in understanding their disease. Molina Healthcare has a special interest in asthma, as it is the number one chronic diagnosis for our Members. This program was developed with the help of several community Providers with large asthma populations. The program educates the Member and family about asthma symptom identification and control. Our goal is to partner with you to strengthen asthma care in the community.

## Building Brighter Days Adult Depression Management Program

The Building Brighter Days - Depression Management Program is a collaborative team approach comprised of health education, clinical case management and provider education. The overall goal is to provide better overall quality of life, quality of care and better clinical outcomes for Members who have a primary psychiatric diagnosis of major depressive disorder. This will be accomplished by providing disease-specific measurable goals for Members and their support systems that are also easily measured by Molina staff and by members.

The Molina team works closely with contracted practitioners in the identification assessment and implementation of appropriate interventions for adults with depression. Molina's Building Brighter Days Program strives to improve outcomes through early identification, continual, rather than episodic, care and monitoring, and most importantly interventions focused on self-advocacy and empowerment of the Member.

## Weight Management

Molina's Weight Management program is comprised of one-on-one telephonic education and coaching by a health educator to support the weight management needs of the Member. The Health Education staff work closely with the Member, providing education on nutrition, assessing the Member's readiness to lose weight, and supporting the Member throughout their participation in the Weight Management Program. The Health Education staff work closely with the Member's Provider to implement appropriate intervention(s) for Members participating in the program. The program consists of multi-departmental coordination of services for participating

Members and uses various approved health education/information resources such as: Centers for Disease Control and Prevention, National Institute of Health and Clinical Care Advance system for health information (i.e. Healthwise Knowledgebase). Health Education resources are intended to provide both general telephonic health education and targeted information based on the needs of the individual.

## Smoking Cessation

MHC Members are eligible for Provider cessation counseling, medications as prescribed, referrals to group counseling or classes, and telephonic counseling. We refer to Kick It California for telephonic counseling. Providers may refer directly to Kick It California by using their online referral system. Members may call Kick It California directly at 1-800-300-8086 or visit: https://kickitca.org/our-program. For tobacco chewers, call 1-800-987-2908.

For services in other languages, please call the following numbers:

**Vape Cessation Services**

- English Tel: (844) 866-8273 or Text “Quit Vaping” to 66819
- Spanish Tel: (800) 600-8191 or Text “No Vapear” to 66819

**Tobacco Cessation Services**

- English Tel: (800) 300-8086 or Text “Quit Smoking” to 66819
- Spanish Tel: (800) 600-8191 or Text “Dejar De Fumar” to 66819
- Chinese Tel: (800) 838-8917
- Korean Tel: (800) 556-5564
- Vietnamese Tel: (800)778-8440

PCPs can prescribe nicotine replacement therapy to use in conjunction with the behavior modification program by faxing a completed Medication Prior Authorization Request Form (only needed for certain NRTs) along with the prescription to (866) 508-6445, Phone: 855-322-4075 For a list of group counseling, support groups or classes in all counties of operation for referral by providers please visit Molina’s provider website at:
https://www.molinahealthcare.com/providers/ca/medicaid/forms/~/media/Molina/PublicWebsite/PDF/Providers/ca/medicaid/forms/tobacco-cessation-group-counseling-and-classes.pdf

## Diabetes Prevention Program

Molina Healthcare offers the Diabetes Prevention Program (DPP) to eligible members. The DPP is an online lifestyle change program that focuses on member engagement and health outcomes and is recognized by the Centers for Disease Control and Prevention (CDC). It was developed to prevent type 2 diabetes and is designed for members who have been diagnosed with prediabetes or are at risk for type 2 diabetes. This program is not for members who already have diabetes. Trained coaches lead the program to help members change certain aspects of their lifestyle focusing on healthy

eating, stress reduction, and physical activity to create long term changes and lasting results.

The DPP takes referrals from network providers, self-referring members, and Molina staff. Members will take a short online assessment to verify program eligibility. Please refer Molina members to the following website to enroll and participate in the program: http://www.yeshealth.com/molina.

### Process for Referring an MHC Member to Health Management Services

- Obtain agreement for a referral to Health Management from the Member;
- Stress compliance as part of the Member's overall care plan;
- Refer Member for only one condition at a time. This will help the Member not feel overwhelmed;
- Complete the Molina Healthcare Health Education Referral Form available on MHC's website in the frequently used forms area;
- Fax Health Education Referral Form and supporting documentation to (800) 642-3691
- Document referral in the Member's medical record;
- Reinforce key concepts and compliance with Member at follow-up office visits.

## Additional Health Education Resources

### Written Patient Education Materials

MHC has patient education materials in key subject areas such as Appropriate Use of Healthcare Services, Risk Reduction and Healthy Lifestyles, and Self-Care and Management of Health Conditions. The most appropriate setting for a Member to receive written literature is from his or her primary care practitioner (PCP) with a brief discussion. Health education materials are used to supplement the patient teaching that occurs in the provider offices, provide reinforcement for the telephonic counseling, or as stand-alone pieces that support self-care initiatives.

MHC recognizes the need for the availability of low literacy health education materials in the Member's preferred languages. We offer a variety of low literacy materials available in English, Spanish, and other languages as requested. Network physicians may download and print health education materials from the provider website to meet the needs of Molina Members at: https://www.molinahealthcare.com/providers/ca/medicaid/resource/Health-Education-Materials.aspx

Members may also download and print health education materials in the topic area of interest from the Member website. These materials are provided at no cost to physicians or our Members. We will translate materials into other languages and alternative formats, at no cost to the provider or Member, as requested.

MHC Members with low vision or who are blind should be offered materials in alternate formats including **large font, Braille or audio.** MHC's contracted providers/practitioners can request materials in alternative formats by contacting the Member and Provider Contact Center.

### Member Newsletters

Molina produces newsletters such as the Guide to Accessing Quality Healthcare. The newsletters contain a variety of topics suggested by Members and the California Department of Health Care Services. Key Plan telephone numbers and resources are provided to assist Members in using their plan benefits appropriately. The contents are for information only and do not take the place of Provider/Practitioner advice. All newsletters are made available on the Molina website under Health and Wellness: https://www.molinahealthcare.com/providers/ca/medicaid/comm/newsletters.aspx. Additionally, the preventive health guidelines are posted on our website to keep families on track with obtaining recommended physical examinations and tests: https://www.molinahealthcare.com/providers/ca/medicaid/resource/CA_PHGs.aspx.

### Individual Medical Nutrition Therapy (Registered Dietitian "RD" services)

For directly contracted Providers/Practitioners, MHC will provide individual medical nutrition therapy for high- risk conditions with a Provider/Practitioner referral. Complete the Health Education Referral form and indicate risk condition. Attach recent lab results and progress notes to assist the RD in counseling the Member most appropriately. All documentation from the appointment with the RD will be sent back to the Provider/Practitioner for inclusion in the Member's medical record.

## Health Plan Oversight (Health Education and Quality Improvement Monitors IPAs/Medical Groups)

### Medical Record Audits and Facility Reviews

As part of the Site Review Program, Certified Site Reviewers (CSRs) conduct Medical Record Review (MRR)audits to verify that preventive services screening and counseling are documented in the Member's medical record. For additional information on the MRR, see the Credentialing: Site Review Program Section of this Provider Manual.

### Focused Studies

Quality Improvement executes studies using various indicators. Data from multiple sources may be used, including medical record review, pharmacy utilization, and preventive care utilization.

## Health Education Services

Matrix distinguishing health education service to the IPA affiliated practitioners versus directly contracted practitioners.

Program/Service labeled “X” are MHC programs/services that are available to both directly contracted practitioners and IPA affiliated Practitioners.

| Health Education Services | Directly Contracted Practitioners | IPA Affiliated Practitioners |
|---|---|---|
| Smoking Cessation Program | X | X |
| Breathe With Ease Asthma Program (2-56 years old)* | X | X |
| Member materials such as brochures, fact sheets,etc. (downloadable from our website) that practitioners can give to MHC Members during the office visit. | X | X |
| Community program referrals | X | X |
| Weight Management Program (18 years old and above) | X | X |
| Education for any of the following:<br>• Appropriate use of health care services<br>• Risk-reduction and healthy lifestyles<br><br>Self-care and management of healthconditions | X | IPA Responsibility |
| Referrals for MHC Member identified as needing Medical Nutrition Therapy for a specifichealth condition | X | IPA Responsibility |

*****These programs are not available to LA County Members but may be offered by their primary contracted health plans.

# 5. CULTURAL COMPETENCY AND LINGUSTIC SERVICES

## Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act., the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA), and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (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 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: https://www.molinahealthcare.com/providers/ca/medicaid/resource/cme.aspx from your local Provider Services Representative and by calling the Molina Member & Provider Services at (855) 322-4075.

## Nondiscrimination in Healthcare Service Delivery

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Member Handbook located at https://www.molinahealthcare.com/members/ca/en-us/-/media/Molina/PublicWebsite/PDF/members/ca/en-us/Medi-Cal/2022-_EOC.pdf.
3. You **MUST** post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found in the Member Handbook located at https://www.molinahealthcare.com/members/ca/en-us/-/media/Molina/PublicWebsite/PDF/members/ca/en-us/Medi-Cal/2022-_EOC.pdf.
4. If a Molina Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP"). Molina provides language assistance services that are free of charge, accurate and timely, and that protect the privacy and independence of limited English proficient (LEP) members.

You can find resources on accessing Molina's interpreter services at https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ca/MediCal/cultural-and-linguistic-services.
Resources on meeting your LEP obligations can be found at https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html;
See also, https://www.hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.

5. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

| | |
|---|---|
| Civil Rights Coordinator<br>Molina Healthcare, Inc.<br>200 Oceangate, Suite 100<br>Long Beach, CA 90802<br>Phone (866) 606-3889<br>TTY/TDD, 711<br>civil.rights@MolinaHealthcare.com | Office of Civil Rights<br>U.S. Department of Health and Human Services<br>200 Independence Avenue, SW<br>Room 509F, HHH Building<br>Washington, D.C. 20201<br>Website:<br>https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf<br>Complaint Form:<br>https://www.hhs.gov/ocr/complaints/index.html |

If you or a Molina Member needs additional help or more information, call (800) 368-1019 or Hearing Impaired TTY/TDD (800) 537-7697.

## Cultural Competency

Molina is committed to reducing healthcare disparities. Training employees, Providers and their staff, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina integrates Cultural Competency training into the overall Provider training and quality monitoring programs. An integrated quality approach intends to enhance the way people think about our Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

## Provider and Community Training

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

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

1. Provider written communications and resource materials
2. On-site and webinar cultural competency training
3. Online cultural competency Provider training modules and videos. These can be found on Molina's website here: https://www.molinahealthcare.com/providers/ca/medicaid/resource/cme.aspx
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 also ensure access to programs, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with limited English proficiency to provide meaningful access to interpretation services when needed. Based on the needs of the member, Molina may deliver interpretation in person, via Video Remote Interpretation (VRI), or over the phone.

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, electronic files), leading to better communication, understanding and Member satisfaction. Online materials found on https://www.molinahealthcare.com/providers/ca/medicaid/resource/Health-Education-Materials.aspx 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.

## Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center at (855) 322-4075. 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.

Molina offers Video Remote Interpretation (VRI) if a telephonic interpreter will not provide meaningful access for an appointment. VRI can be accessed through any standard smartphone, tablet, or laptop equipped with a webcam. No specific software is needed, and the platform is HIPAA compliant and can be used for telehealth visits as well as in-person appointments. VRI appointments can be requested by calling the

Contact Center at (855) 322-4075. Requests should be made 48 hours in advance of an appointment.

Molina offers qualified onsite interpreter services to Providers and Members at medical appointments based on complex medical cases. Providers and Members may call Molina's Contact Center at (855) 322-4075 to submit a request. Requests should be made three days in advance of an appointment.

## 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. Information should include the interpreter's name, operator code, and vendor
- Document all counseling and treatment done using interpreter services
- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after being notified of their 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 & Provider Contact Center, Quality, HealthCare Services and all other health plan functions.

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

Molina will provide video remote interpreter or 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, seven days per week. The Nurse Advice Line provides access to 24-hour access to interpretive services. Members may call Molina's Nurse Advice Line directly, English line at (888) 275-8750 or Spanish line at (866) 648-3537, or for assistance in other languages. The

Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

## Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within 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.

# 6. PROVIDER RESPONSIBILITIES AND INFORMATION

## Nondiscrimination in Healthcare Service Delivery

Providers must comply with the nondiscrimination of health care service delivery requirements as outlined in the Cultural Competency and Linguistic Services section of this Provider Manual.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to source of payment. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost sharing from a government-funded program.

## Section 1557 Investigations

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

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

Toll Free: (866) 606-3889
Hearing Impaired (TTY/TDD): 711
On-line: https://MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Should you or a Molina Member need more information, refer to the Health and Human Services website: https://www.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).

Providers may check the status of their enrollment on the California Health and Human Services Open Data Portal by visiting: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as- of-june-1-2017

More information regarding this requirement is available in APL 17-019 on the DHCS website.

## Provider Data Accuracy and Validation

It is important for Providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Provider Network and Members.

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. MHC is required to publish and maintain accurate provider directories in accordance with SB 137 and Health and Safety Code Section 1367.27. Invalid information can negatively impact Member access to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers must validate their Provider information on file with Molina at least once every 90 days for correctness and completeness.

Additionally, in accordance with the terms specified in your Provider Agreement, Providers must notify Molina of any changes, as soon as possible, but at a minimum 30 calendar days in advance of any changes in any Provider information on file with Molina. Changes include but are not limited to:

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

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement.

Please visit our Provider Online Directory at: providersearch.MolinaHealthcare.com to validate your information. Providers can make updates through the CAQH portal, or you may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice. Providers unable to make updates through the CAQH portal, or roster process, should contact their Provider Services representative for assistance.

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

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as: letters, phone campaigns,

face-to-face contact, fax and fax-back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts its Provider Directory or otherwise impacts its membership or ability to coordinate Member care. Providers are required to provide timely responses to such communications.

## National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, 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 (FAQ) 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.

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

Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Molina Availity Essentials portal.

Any providers 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 Molina's Availity Essentials 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 (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)
- Availity Essentials portal

## Electronic Claims Submission Requirement

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

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare of California via the Availity Essentials portal.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 38333 refer to our website MolinaHealthcare.com for additional information.

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

Availity Essentials portal Claims submission includes the ability to:

- Add attachments to previously submitted 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/un-submitted Claims
- Create/Manage Claim Templates

For more information on EDI Claims submission, see the Claims and Compensation Encounter Data 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 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 processes.

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website at: MolinaHealthcare.com.

## Availity Essentials Portal

Providers and third-party billers can use the no cost Availity Essentials 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 (CMS1500) and Institutional (UB04) Claims with attached files
  - Correct/Void Claims
  - Add attachments to previously submitted Claims
  - Check Claims status
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - 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
- Download forms and documents
- Send/receive secure messages to/from Molina

## Balance Billing

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

Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

## Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials (such as Member Handbooks).

For additional information please refer to the Member Rights and Responsibilities section of this Provider Manual.

## Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and be approved by Molina prior to use.

Please contact your Provider Services representative for information and review of proposed materials.

## Member Eligibility Verification

Possession of a Molina Medi-Cal 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.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- Availity Essentials portal at: provider.MolinaHealthcare.com
- Molina Provider Services automated IVR system at (855) 322-4075

For additional information please refer to the Eligibility, Enrollment, Disenrollment and grace Period section of this Manual.

## Member Cost Share

Providers should verify the Molina Member's cost share status prior to requiring the Member to pay copay, coinsurance, deductible or other cost share that may be applicable to the Member's specific benefit plan. Some plans have a total maximum cost share that frees the Member from any further out-of-pocket charges once reached (during that calendar year).

## HealthCare Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina's 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 physician'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 physician'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: appointment.questdiagnostics.com/patient/confirmation and labcorp.com/labs-and-appointments.

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 may become 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. 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 in the patient's medical record any referrals that are made. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers which 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 hospital emergency room. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Molina for all out-of-network care/treatment with the exception 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 referral request to Molina. However, referral and prior authorization requirements may vary for members assigned to an IPA/Medical Group. Please verify prior authorization and referral requirements with the IPA/Medical Group prior to rendering services.

## 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.

## Pharmacy Program

Providers are required to adhere to Molina's drug formularies and policies for Prescription Administered Drugs billable to Molina. For additional information please refer to the Pharmacy 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
- Delivery of Patient Care Information

For additional information please refer to the Quality section of this 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 its contracted Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member protected health information. 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 and appeal, the Provider will participate by providing medical records or statement if needed. This includes the maintenance and retention of Member records for a period of not less than 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 Complaints, Grievance and Appeals section of this 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. 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 section of this Provider Manual.

## Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegated Services Addendum, applicable laws and accreditation standards this Provider Manual. Please see the Delegation section of this Provider Manual for more information about Molina's delegation requirements.

## Primary Care Provider Responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with Molina
- Triage appropriately
- Notify Molina of Members who may benefit from Care Management
- Participate in the development of Care Management treatment plans

## Provider Engagement

Molina has a dedicated team with locally based Provider Services Representatives who facilitate education sessions to ensure providers clearly understand our requirements and programs. The Provider Services Representatives deliver provider training, including but not limited to DHCS regulatory requirements, while also supporting issue resolution and conveying knowledge of compliance requirements with Molina Policies and Procedures. In addition, Provider Service Representatives communicate to providers their rights and responsibilities, while offering support in navigating our processes and network. Specific training materials on various services are accessible to providers and their staff 24/7 365 days through our website, Availity Essentials portal: provider.MolinaHealthCare.com

The provider Services Representatives also conduct in-person or virtual office visits and schedule Town Halls and/or Lunch & Learns for additional training opportunities regarding these services.

# 7. 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 (800) 526-8196, ext. 126137 or fax (562) 499-6185.

The address for mail requests is:

Molina Healthcare of California
Quality Department
200 Oceangate, Suite 100
Long Beach, CA 90802

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

Molina has established a Quality Improvement Program that complies with regulatory and accreditation guidelines. The 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 and 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 case management/disease management programs and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

## Quality of Care

Molina has an established and 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 found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgery on a patient

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

## Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member’s record. PCPs should maintain the following components, that include but are not limited to:

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

### Medical Record Keeping Practices

Below is a list of the minimum items that are necessary in the maintenance of the Member’s Medical records:

- Each patient has a separate record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available at each visit and archived records are available within 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 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.
- 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 Advances 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.
- 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 medial information for facilitation of medical care.

### Retrieval

- The medical record is available to Provider at each encounter.
- The medical record is available to Molina for purposes of Quality improvement.
- The medical record is available to -the applicable State and/or Federal agency and the External Quality Review Organization upon request.
- The medical record is available to the Member upon their request.
- A storage system for inactive Member medical records which allows retrieval within 24 hours, is consistent with State and Federal requirements, and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one year past their 20th birthday but, never less than 10 years.
- An established and functional data recovery procedure in the event of data loss.

### Confidentiality

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

- Ensure that medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas
- Maintain records and information in an accurate and timely manner
- Ensure timely access by Members to the records and information that pertain to them

- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health an enrollment information
- Medical Records are protected from unauthorized access
- Access to computerized confidential information is restricted
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information
- Education and training for all staff on handling and maintaining protected health care information

Additional information on medical records is available from your local Molina Quality department toll free at (800) 526-8196, ext. 126137 See also the Compliance Section of this Provider Manual for additional information regarding HIPAA.

## Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Provider surveyed include OB/GYN (high-volume specialists), Hematology/Oncologist (high-impact specialists), and behavioral health Providers. 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 ninety percent 80 percent availability for Emergency Services and 80 percent or greater for all other services (these goals may vary by plan). The PCP or his/her designee must be available 24 hours a day, seven days a week to Members.

### Appointments with the Primary Care Practitioner (PCP)

Members are instructed through their member handbook to call their PCP to schedule appointments for routine/non-urgent care, preventive care and urgent/emergency care visits. The PCP is expected to ensure timely access to MHC members. If the need for specialty care arises, the PCP is responsible for coordinating all services that fall out of the scope of the PCP's practice.

### Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members within the noted timeframes. Molina will implement corrective actions for access to health care services that do not meet the performance standards.

### Behavioral Health Appointment

| Appointment Types | Standard |
|---|---|
| Urgent Care with a Behavioral Health Provider without prior authorization | Within ≤ 48 hours of the request. |
| Urgent Care requiring prior authorization with a Behavioral Health Provider | Within ≤ 96 hours of the request. |

| | |
|---|---|
| Routine or Non-Urgent Care Appointments with a Behavioral Health Provider | Within ≤ 10 working days of the request. |
| Behavioral Health Non-life-threatening emergency | Within ≤ 6 hours of the request. |
| BH – Routine Follow Up with Prescribers (i.e. Psychiatrist) | Within ≤ 30 business days from the initial appointment for a specific condition |
| BH – Routine Follow Up with Non-Prescribers (i.e. Psychologist) | Within ≤ 20 business days from the initial appointment for a specific condition |
| Routine or Non-Urgent Care Appointment with a Non- Physician Mental Health Provider | Within ≤ 10 working days of the request. |

Additional information on access to care is available from your local Molina Quality department.

## Standards of Accessibility

Access standards have been developed to ensure that all health care services are provided in a timely manner, however, the waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health care professional providing triage or screening services, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and documented in the relevant patient medical record that a longer waiting time will not have a detrimental impact on the health of enrollee.

These standards are based on regulatory and accreditation standards. MHC monitors compliance to these standards. All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted:

| Appointment Types | Standard |
|---|---|
| Emergency Care | Immediately |
| PCP Urgent Care without prior authorization | Within ≤ 48 hours of the request. |
| PCP Urgent Care with prior authorization | Within ≤ 96 hours of the request. |
| PCP Routine or Non-Urgent Care Appointments | Within ≤ 10 business days of the request. |
| PCP Adult Preventive Care | Within ≤ 20 business days of the request. |
| Specialist Urgent Care without prior authorization | Within ≤ 48 hours of the request. |
| Specialist Urgent Care with prior authorization | Within ≤ 96 hours of the request. |
| Specialist Routine or Non-Urgent Care | Within ≤ 15 business days of the request. |
| Routine or Non-Urgent Care Appointment for Ancillary Services | Within ≤ 15 working days of the request. |

| Appointment Types | Standard |
|---|---|
| Children's Preventive Period Health Assessments (Well-Child Preventive Care) Appointments | Within ≤ 7 working days of the request. |
| After Hours Care | 24 hours/day; 7 day/week availability |
| Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA) for a New Member (under 18 months of age) | Within 120 days of the enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages 2 and younger, whichever is less. |
| Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA) for a New Member (over 18 months of age through 20 years of age) | Within 120 days of the enrollment. The IHA and SHA must follow most recent AAP periodicity schedule appropriate for the child's age, and the scheduled assessments and services must include all content required by the Child Health and Disability Prevention program (CHDP) for the lower age nearest to the current age of the child. |
| Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA) for a New Member (age 21 years and older) | Within 120 days of the enrollment. |
| Maternity Care Appointments for First Prenatal Care | Within ≤ 2 weeks of the request. |
| Office Telephone Answer Time (during office hours) | Within ≤ 30 seconds of call. |
| Office Response Time for Returning Member Calls (during office hours) | Within same working day of call. |
| Office Wait Time to be Seen by Physician (for a scheduled appointment) | Should not exceed 30 minutes from the appointment time. |
| After-Hour Instruction for Life-Threatening Emergency (when office is closed) | Life-threatening emergency instruction should state: "If this is a life-threatening emergency, hang up and dial 911." |
| Physician Response Time to After-Hour Phone Message, Calls and/or Pages | Within 30 minutes of call, message and/or page. A clear instruction on how to contact the physician or the designee (on-call physician) must be provided for Members. |

## After-Hour Availability

| After-hour Availability | After-hour Access Standards |
|---|---|
| Appropriate after-hour emergency instruction. | If this is a life-threatening emergency, please hang up and dial 911. |
| Timely physician response to after hour phone calls/pages. | Within ≤ 30 minutes. |

## Ancillary Appointment

| Ancillary Access Type | Ancillary Access Standards |
|---|---|
| Non-urgent appointment for ancillary services. | Within ≤ 15 business days. |

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

## Office Wait Time

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

## After Hours Care

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 a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room. Voicemail alone after-hours is not acceptable.

## Primary Care Office Hours

Generally, office hours are from 9:00 a.m. to 5:00 p.m. However, the Provider/Practitioner has flexibility to maintain his/her own reasonable and regular office hours. All primary care sites are required to post their regular office hours and be available to the members at least 20 hours a week at the site. Answer time for a live person in the office to converse with a Member caller is within 45 seconds of the call during office hours. Response time for returning Member calls during office hours is within the same business day of the call. Office wait time to be seen by the physician for a scheduled appointment should not exceed 30 minutes from the appointment time.

## Urgent and Emergency Care at the Primary Care Practitioner's Office

The facility must have procedures in place to enable access to emergency services 24 hours a day, seven days a week. The facility staff needs to be knowledgeable about emergency procedures and be capable of coordinating emergency services. The recommended equipment for required emergency procedures needs to be easily accessible.

The emergency inventory list needs to be posted with drug expiration dates. Examples of emergency drugs are epinephrine and Benadryl. Oxygen needs to be secured, full, and equipped with a flow meter. The mask and Cannula need to be attached. Oral airways and ambo bags appropriate for patient population need to be available. (Refer

to DHCS Facility checklist, Physician Facility Reviews). If there is need for Basic Life Support or Emergency Medical Services (EMS), dial 911.

## Appointment Scheduling

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

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

2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the Molina Provider Services department.

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

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

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

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

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

### Women's Health Access

Molina allows Members the option to seek obstetrical and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina 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 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 the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, and after-hours access
2. Member complaint data – assessment of Member complaints related to access to care
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

## 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 of 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 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 is 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, 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 physician
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice
- At least one CPR certified employee is available
- Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with 10 or more employees
- A container for sharps is located in each room where injections are given
- Labeled containers, policies, and contracts evidence of a hazardous waste management system in place.
- 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
- Narcotics are locked, preferably double locked. Medication and sample access are restricted
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates
- Drug refrigerator temperatures are documented daily

## Advance Directives (Patient Self-Determination Act)

Molina complies with the advance directive's 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. There are two types of Advance Directives:

- **Durable Power of Attorney for Health Care**: allows an agent to be appointed to carry out health care decisions
- **Living Will**: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration
- **5 Wishes**: records an end-of-life care plan for future care in case someone is unable to make decisions for themselves at that time. It documents care and comfort choices.

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

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

Members who would like more information are instructed to contact Member Services or are directed to the CaringInfo website at caringinfo.org/planning/advance-directives/ 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 survey and certification agency if the Member is dissatisfied with Molina's handling of Advance Directives and/or if a Provider fails to comply with Advance Directives instructions.

For members that are active with Molina's Care Management program, Molina will notify the Provider via fax of an individual Member's Advance Directives if the information is available. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are State specific to meet State regulations.

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

## EPSDT Services to Enrollees Under 21 Years of Age

Molina maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnosis 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 and Healthcare Services Departments are 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 (please also refer to the Children's Preventive Services section of this manual)

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

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height and 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.
- Vision and hearing tests.
- Dental assessment and services.
- Health education, including anticipatory guidance such as child development, healthy lifestyles, accident and disease prevention.
- Periodic objective screening for social emotional development using a recognized, standardized tool.

- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit.

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 (e.g. carved out of Molina's contract with the state).

Molina cannot pay for services that are not Covered Services. However, if the PCP believes the service is medical in nature, and medically necessary to correct or ameliorate a child/youth's medical condition, then a prior authorization request for that service should be submitted to Molina for consideration under the EPSDT benefit. If the service is needed, but cannot be covered by Molina, MHC will work with the provider to assign a pediatric Case Manager to assist the patient/family to obtain the service through other resources.

## Monitoring for Compliance with Standards

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

## Timely Access to Care: Sensitive and Confidential Services for Adolescents and Adults

Sensitive Services means those services related to:

- Sexual Assault
- Drug or alcohol abuse for children 12 years of age or older
- Pregnancy
- Family Planning
- Sexually transmitted diseases for children 12 years of age or older
- Abortion services
- HIV testing/counseling
- Mental Health Services
- Health Education Services

The following is a brief guide on providing access to Members for these sensitive areas.

### Timely Access to Services and Treatment Consent

Members under the age of 12 years require parental or guardian consent for obtaining services in the areas of sexually transmitted diseases or drug/alcohol abuse. Minors under the age of 12 years seeking abortion services are subject to State and Federal law. Those age 12 and over can obtain any and all of the above services by signing the Authorization for Treatment form. Timely access is required by Providers/Practitioners for members seeking the sensitive/confidential medical services for family planning and/or sexually transmitted diseases, HIV testing/counseling, as well as for confidential referrals for treatment of drug and/or alcohol abuse.

### Family Planning Services

To enhance coordination of care, PCPs are encouraged to refer Members to MHC Providers/ Practitioners for family planning. Members, however, do not require prior authorization from their PCP to seek family planning services. This freedom of choice provision is the result of Federal legislation.

### Privacy and Security of Protected Health Information

Member and patient Protected Health Information (PHI) should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider/Practitioner may use and disclose PHI for their own treatment, payment and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. In addition, Providers/Practitioners must implement and maintain appropriate administrative, physical, and technical safeguards to protect the confidentiality of medical records and other PHI. Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. In general, most California healthcare Providers/Practitioners are subject to the following laws and regulations pertaining to privacy of health information:

- Federal Laws and Regulations
    - HIPAA
    - Medicare and Medicaid laws
- California Laws and Regulations
    - Confidentiality of Medical Information Act (CMIA)
    - Patient Access to Health Records Act (PAHRA)

## Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program (QIP). 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 (CPG) 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 approved by the Quality Improvement Committee.

Molina Clinical Practice Guidelines include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness-Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health

Education and Member Services departments. The guidelines are disseminated through Provider newsletters, 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:

- Recommendations for Preventive Pediatric Health Care
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States, 2022
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

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 an 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 program and services, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

## Measurement of Clinical and Service Quality

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

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

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

Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance

data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

Molina's most recent results can be obtained from your local Molina Quality functional area at (800) 526-8196, ext. 126137or by visiting our website at: MolinaHealthcare.com.

## Healthcare Effectiveness Data and Information Set (HEDIS®)

MHC 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, medication use and cardiovascular disease.

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

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

## Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is the tool used by Molina to summarize member satisfaction with the behavioral and non-behavioral 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 Healthcare 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 MHC's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

## Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on member experience with health care providers and health plans, MHC 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 requests for out-of-network services to determine opportunities for service improvements.

## What Can Providers Do to Help Ensure Quality?

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

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Availity Essentials 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 Molina's Quality department.

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

## Benefits and Services

The PCP should encourage Members to seek family planning services from Providers/Practitioners within MHC. This process will help to coordinate care and maintain continuity, supporting better health outcomes. Members have the right to access family planning services in a timely manner without need of prior authorization. Members need to access medical care based on the nature of their medical problem.

Members may request a referral for drug and/or alcohol treatment programs. Please refer to Healthcare Services Section: Additional Services or Carve-out Services for further details and a list of benefits of the drug and alcohol program. Members will receive obstetrical services according to the Pregnancy and Maternal Care policy found in Compliance Section: Women's and Adult Health Services, Including Preventive Care. Members may receive family planning services from in plan or out of plan Providers/Practitioners as outlined in Compliance Section.

# EMERGENCY CARE

## Emergency Care

Emergency Services means those services needed to evaluate or stabilize an Emergency Medical Condition. Emergency Medical Condition means a medical condition which is manifested 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 individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part

Emergency services using the prudent layperson definition or that meet Title 22 criteria for an emergency, do not require MHC prior authorization. In accordance with California Department of Health Care Services' policies and current law, members presenting to an emergency room facility may be triaged by the emergency room staff, and MHC will pay the Medical Screening Exam fee.

## Emergency Department Support Unit (EDSU)

Molina highly encourages that requests for authorization of post-stabilization services be communicated telephonically via the EDSU. While the member is in the Emergency Room, call (844) 9-Molina or (844) 966-5462. Additionally, **clinical records for authorization of post-stabilization care can be faxed to the dedicated EDSU fax number: (877) Molina 5 or (877) 665-4625.** This fax number is used exclusively for members currently in the ER, to help expedite requests and assist with discharge planning.

Molina Healthcare's Emergency Department Support Unit (EDSU) will collaborate with you to provide assistance to ensure our members receive the care they need, when they need it.

The EDSU is a dedicated team, available twenty-four (24) hours a day, seven (7) days a week to provide support by:

- Assisting you in determining appropriate level of placement using established clinical guidelines
- Issuing authorizations for post-stabilization care, transportation, or home health
- Involving a Hospitalist or On-Call Medical Director for any Peer-to-Peer reviews needed
- Working with pharmacy to coordinate medications or infusions as needed
- Obtaining SNF placement if clinically indicated
- Coordinating placement into Case Management with Molina when appropriate
- Beginning the process of discharge planning and next day follow-up with a primary care provider if indicated.

For EDSU, Call: (844) 966-5462

## Notification Requirements

When a member receives stabilization services in the hospital Emergency Room, Molina requires timely notification to the EDSU for any post stabilization services, i.e. inpatient admission.

Molina strongly recommends that requests for authorization of post-stabilization services be communicated telephonically via the EDSU. Contact with the EDSU will be considered a formal request that requires a determination for post stabilization services and will be responded to within 30 minutes.

| |
|---|
| For EDSU, **please call**: (844) 9-Molina or (844) 966-5462<br><br>Fax clinical documentation to: (877) Molina 5 or (877) 665-4625 |

If there is insufficient clinical information to render an approval during the post stabilization timeframe, the EDSU nurse will contact the Molina physician on call for consultation. If the physician determines that clinical information does not support medical necessity, a denial will be issued. Denials may be overturned if additional clinical information is provided to support medical necessity for the admission.

If transfer or a higher level of care is needed, the hospital will initiate transfer with the EDSU. The EDSU staff will work with the hospital to help facilitate transfer of the member to a facility that is able to provide the level of care needed by the member.

For post stabilization services that are denied for inpatient level of care, the hospital may submit claims for observation level of care for payment consideration.

Notifications received from hospitals, where a post-stabilization admission determination is NOT expected by the hospital within 30 minutes, will follow the standard Molina UM process (determination made within 24 hours) Requests where a determination is not expected within 30 minutes should be faxed to the Standard Inpatient Notification Fax line at (866) 553-9263

## Observation Status

Observation stays up to 72 hours do not require prior authorization and can be billed directly to Molina along with any related charges. Those scenarios where an observation stay needs to be converted to an inpatient stay should follow the Emergent Inpatient Admissions section below.

Any emergency service resulting in an inpatient admission requires MHC notification and authorization within twenty-four (24) hours (or the next business day) of the admission. Furthermore, “Out of Area” and/or non- contracted emergency service Providers/Practitioners are required to notify MHC when the Member’s condition is deemed stable for follow up care in MHC’s service area, at a contracted facility. adheres to the regulations set forth in Title 28, California Code of Regulations, Chapter 3, Section 1300.71.4, Emergency Medical Condition and Post Stabilization Responsibilities for Medically Necessary Health Care Services.

Fax clinical documentation to: (877) Molina 5 or (877) 665-4625

After hours, weekends and holidays, please call: Phone: (844) 9-MOLINA (844) 966-5462

## Emergency Room Discharge and After-Care

Aftercare instructions should be documented in the emergency facility medical record and communicated to the patient, parent, or guardian. Discharge from the emergency facility is performed on the order of a Provider/Practitioner.

For transfer requests and discharge planning authorizations, after hours, weekends and holidays, please call: (844) 9-MOLINA (844) 966-5462

## NURSE ADVICE PROGRAM

MHC provides twenty-four (24) hour Nurse Advice access for members and Providers/Practitioners. Licensed Registered Nurses perform telephone assessment of the member’s complaints, provide telephone triage utilizing standardized guidelines which are reviewed and approved by the Nurse Advice Medical Director, and provide advice within the scope of their Registered Nurse license. Only licensed Registered Nurses offer advice regarding the member’s medical condition and make referrals to appropriate level of care for treatment in accordance with established standards of practice.

The goals of the Nurse Advice program are to:

- Advise and refer Members to appropriate level of care in a timely manner
- Coordinate the Member’s care with the PCP
- Educate Members on health issues
- Assist in identifying Members who might benefit from additional case management services from MHC

The Nurse Advice program is available to Members and Providers/Practitioners twenty-four (24) hour a day by calling: (888) 275-8750 [English] or (866) 648-3537 [Spanish].

Members who contact the Nurse Advice program are referred to MHC Care Management to address any follow up care or services that may be needed.

## 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.

MHC ensures that participating providers provide safe and appropriate physical access to the office site for members with a disability and comply with the Americans with Disabilities Act (ADA) of 1990. Physical access should include, but is not limited to, ease of entry into the building, availability of ramps, elevators, modified restrooms, designated parking spaces close to the facility, accessibility of space within the office site, and drinking water provisions. If any physical barriers to disabled accessibility exist, MHC will discuss potential resolution with the Provider/Practitioner or the contracted IPA/Medical Group.

Access for members with a disability are assessed during the PCP facility site review or Specialist physical access audit conducted by MHC.

## Provider/Practitioner Review Process

### Provider/Practitioner Facility Site Review (FSR)

Effective July 1, 2002, the State of California's Health and Human Services Agency mandated that all County Organized Health Systems (COHS), Geographic Managed Care (GMC) Plans, Primary Care Case Management (PCCM) Plans, and Two-Plan Model Plans use the Full Scope Site Review and Medical Record Review Evaluation Tool. For more details on FSR, please reference: Facility Site Review.

All primary care sites serving Medi-Cal managed care Members must undergo an initial site review and subsequent periodic site review every three (3) years using the current DHCS approved facility site review survey tool. Managed care health plans may review sites more frequently per local collaborative decision or when determined necessary, based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues. For more details on FSR, please reference: Facility Site Review.

The Medi-Cal managed care health plans within the county have established systems and procedures for the coordination and consolidation of site audits for mutually shared PCP sites and facilities to avoid duplication and overlapping of FSR reviews. For more details on FSR, please reference: Facility Site Review.

## Medical Record Review (MRR)

The on-site Practitioner/Provider medical record review is a comprehensive evaluation of the medical records. MHC will provide information, suggestions and recommendations to assist Practitioners/Providers in achieving the standards. For more details on MRR, please reference: Facility Site Review.

All PCPs must complete and pass the medical record review at each practice location. Medical Record Reviews are conducted in conjunction with the Facility Site Review, prior to participating in MHC Provider Network and at least every three (3) years thereafter. For more details on MRR, please reference: Facility Site Review.

All Primary Care Physicians must maintain an Exempted or Conditional pass on medical record review to participate in MHC Provider Network. The evaluation scores are based on standardized scoring mechanism established by DHCS. Please refer to the Credentialing section of the Provider Manual for expanded information about MRR requirements. For more details on MRR, please reference: Facility Site Review.

## Physical Accessibility Review Survey (PARS)

In accordance with the California Department of Health Care Services (DHCS), Medi-Cal Managed Care Division (MMCD) policy letter 11-013, managed care health plans are required to assess the level of physical accessibility of Provider sites, including all Primary Care Physicians, specialists and ancillary Providers that serve a high volume of Seniors and Persons with Disabilities (SPD). The Physical Accessibility Review Survey (PARS) tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA). For more details on PARS, please reference: Facility Site Review.

Unlike the Facility Site Review and Medical Records Review, PARS is a survey, and no corrective action is required. Please refer to the Credentialing section of the Provider Manual for expanded information about PARS requirements. For more details on PARS, please reference: Facility Site Review.

## Child Health and Disability Prevention (CHDP)/Early Periodic Screening Diagnosis and Treatment (EPSDT) Reviews

CHDP/EPSDT is a State/Federal preventive service program that delivers periodic health assessments and services to low-income children and youth in California. CHDP/EPSDT provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

MHC provides health assessment, preventive health care and coordination of care to eligible Members through the CHDP/EPSDT program.

CHDP/EPSDT-specific questions are incorporated into the Medical Record Review Tool. The CHDP/EPSDT review may be done concurrently with the medical record review.

CHDP/EPSDT requirements are detailed in the Medical Record Pediatric Review Guidelines.

## Comprehensive Perinatal Services Program (CPSP) Review

The CPSP is designed to increase access to prenatal care and to improve pregnancy outcomes. The services of this program include health and nutrition education, psychosocial assessment, treatment planning, and periodic reassessment. CPSP must be offered to all MHC Medi-Cal Members, but participation is voluntary. Refusal of CPSP must be documented in the patient's obstetrical record.

# 8. MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual.

Member Handbooks are available on Molina's Member Website. Member Rights and Responsibilities are outlined under the heading "Your Rights and Responsibilities" within the Member Handbook document.

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

## Second Opinions

If Members do not agree with their Provider's plan of care, they have the right to a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. If possible, the second opinion provider should be contracted with Molina. Second opinions may require Prior Authorization. If a non-contracted provider is requested, the second opinion request will require prior authorization.

## Member Benefits

Health care professionals contracted with the State of California's Medi-Cal Program are obligated to provide member services in accordance with standards as to frequency, access, and medical office policies and procedures. The following gives a brief overview of these obligations.

Physicians from the following categories are eligible to be a Primary Care Physician (PCP); Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology (OB/GYN), and Pediatricians. PCPs may self- restrict their practice by age or sex. Molina Healthcare of California (MHC) may restrict member assignment to a PCP by age or sex (e.g., OB/GYN may be restricted to adult women, Pediatricians to children and adolescents).

PCPs must be able to provide the full range of preventative and acute health care and Comprehensive Medical Case Management services for all members assigned to them.

## PCP Scope of Services Requirements

PCPs are required to provide the following services to Members assigned to them:

- Detect, diagnose, and effectively manage common symptoms and physical signs

- Treat and manage common acute and chronic medical conditions
- Perform ambulatory diagnostic and treatment procedures (injections, aspirations, splints, minor suturing, etc.)
- An Initial Health Assessment (IHA) within one-hundred-twenty (120) days of a member's enrollment or within periodicity timelines established by the American Academy of Pediatrics for ages two and younger, whichever is less. The IHA must include a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services, health education, and the diagnosis and plan for treatment of any diseases.
- Foster health promotion and disease prevention (age specific screening, health assessment and health maintenance activities, health education and promotion, including healthy lifestyle changes, etc.)
- Provide Comprehensive Medical Case Management (refer to community resources and available supplemental programs, coordinate care with specialists, etc.). Refer to specialists, other providers, and facilities appropriately to member care needs
- Follow required procedures for specialist, diagnostic, or service referral as promulgated by IPA/Medical Group and/or MHC

### Specific Requirements for Serving Molina Healthcare's Medi-Cal-only SPD Members

Refer to coordination of care instructions as described in the Utilization Management section of this Manual (CONTINUITY OF MEMBER CARE).

## Molina Member Rights and Responsibilities

This document explains the rights of MHC's Medi-Cal Members, as stated verbatim as in the Member's Evidence of Coverage (EOC) Guide. Providers/Practitioners and their office staff are encouraged to be familiar with this document, post it in their office (poster provided by MHC), and are expected to abide by these rights. MHC's Member rights and responsibilities statement is as follows:

### What are My Rights and Responsibilities as a Molina Healthcare Member?

These rights and responsibilities are posted in doctors' offices and on the Molina website: MolinaHealthcare.com.

### Your Rights

You have the right to:

- Be treated with respect and recognition of your dignity by everyone who works with Molina
- Get information about Molina, our providers, our doctors, our services and Members' rights and responsibilities

- Choose your “main” doctor from Molina’s network (This doctor is called your Primary Care Doctor or personal doctor)
- Be informed about your health. If you have an illness, you have the right to be told about all treatment options regardless of cost or benefit coverage. You have the right to have all your questions about your health answered
- Help make decisions about your health care. You have the right to refuse medical treatment
- You have a right to Privacy. Molina keeps your medical records private. *
- See your medical record including the results of your Initial Health Assessment (IHA).
- You also have the right to get a copy of and correct your medical record where legally ok.*
- Complain about Molina or your care. You can call, fax, e-mail or write to Molina Member Services
- Appeal Molina’s decisions
- You have the right to have someone speak for you during your grievance
- Ask for a State Fair Hearing by calling toll-free 1 (800) 952-5253. You also have the right to get information on how to get an expedited State Fair hearing quickly
- Disenroll from Molina. (Leave the Molina Health Plan)
- Ask for a second opinion about your health condition
- Ask for someone outside Molina to look into therapies that are Experimental or being done as part of exploration
- Decide in advance how you want to be cared for in case you have a life-threatening illness or injury
- Get interpreter services on a twenty-four (24) hour basis at no cost to you. This service will help you to talk with your doctor or Molina if you prefer to speak a language other than English
- Not be asked to bring a minor, friend, or family member with you to act as your interpreter
- Get information about Molina, your providers, or your health in the language you prefer. (You have the right to request information in printed form translated into the language you prefer)
- Ask for and get materials in other formats such as larger size print or at least eighteen (18)-point font, audio, and Braille upon request. We will get you the materials in a timely fashion appropriate for the format being requested, and in accordance with State laws
- Get a copy of Molina’s list of approved drugs (drug formulary) on request
- Submit a grievance if you do not get medically needed drugs or a seventy-two (72) hour supply through the Molina Pharmacy Network after an Emergency visit at one of Molina’s contracted hospitals
- Have access to family planning services, Federally Qualified Health Centers (FQHCs), Indian Health Services Facilities, Sexually Transmitted Disease (STD) services, and Emergency services outside of Molina’s network according to federal laws. You do not need to get Molina’s approval first
- Get minor consent services

- Not to be treated poorly by Molina, your doctors, or the Department of Health Care Services (DHCS) for acting on any of these rights
- Make recommendations about Molina's Member rights and responsibilities policies
- Be free from controls or isolation used to pressure, punish or seek revenge
- File a grievance or complaint if you believe your language needs were not met by Molina

*Subject to State and Federal laws

## Your Responsibilities

You have the responsibility to:

- Learn and ask questions about your health benefits. If you have a question about your benefits, call toll-free at 1 (888) 665-4621. If you are deaf or hard of hearing, dial 711 for the California Relay Service
- Give information to your doctor, provider, or Molina that is needed to care for you
- Be active in decisions about your health care
- Follow the care plans and instructions for you that you have agreed on with your doctor(s)
- Build and keep a strong patient-doctor relationship. Cooperate with your doctor and staff. Keep appointments and be on time. If you are going to be late or cannot keep your appointment, call your doctor's office
- Give your Molina and state card when getting medical care. Do not give your card to others
- Let Molina or the state know about any fraud or wrongdoing. The Molina Alert Line is available twenty- four (24) hours, seven (7) days a week. To report an issue by telephone, call toll-free at (866) 606-3889
- Understand your health problems and participate in developing mutually agreed-upon treatment goals as you are able

## Be Active In Your Healthcare

Plan Ahead:

- Schedule your appointments at a good time for you
- Ask for your appointment at a time when the office is least busy if you are worried about waiting too long
- Keep a list of questions you want to ask your doctor
- Refill your prescription before you run out of medicine

## Make the Most of Doctor Visits

- Ask your doctor questions
- Ask about possible side effects of any drugs prescribed
- Tell your doctor if you are drinking any teas or taking herbs. Also tell your doctor about any vitamins or over-the-counter drugs you are using

- Visit your doctor when you are sick. Try to give your doctor as much information as you can.
- Tell your doctor if you are getting worse or if your symptoms are staying about the same
- Tell your doctor if you have you taken anything

If you would like more information, please call Molina's Member Services Department toll-free at (888) 665- 4621, Monday through Friday, between 7:00 a.m. and 7:00 p.m. If you are deaf or hard of hearing, dial 711 for the California Relay Service. TTY users dial 711.

## Member Confidentiality

According to MHC's Medi-Cal Member Rights, members have the right to full consideration of their privacy concerning their medical care program. They are also entitled to confidential treatment of Member communications and records.

Case discussion, consultation, examination, Medi-Cal eligibility, and treatments are confidential and should be conducted with discretion. Member Protected Health Information (PHI) should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures 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 the California Civil Code.

## Office Procedure

All participating Providers/Practitioners must implement and maintain office procedures that will guard against disclosure of any PHI to unauthorized persons. These procedures should include at least the following elements:

- Written authorization obtained from the member or his/her legal representative, before medical records or other PHI is disclosed to a third party for a purpose not otherwise permitted or required under applicable Federal or State laws
- All signed authorizations for the use or disclosure of PHI must be carefully reviewed to verify that the authorization is valid and meets the requirements of applicable Federal and State law
- Each medical record and other PHI should be reviewed prior to making it available to anyone other than the Member or legal personal representative of the Member
- Only the portion of the medical record and other PHI specified in the authorization should be made available to the requester and should be separated from the remainder of the Member's medical records

## Confidential Information

Confidential information also refers to any identifiable information about a member's character, conduct, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. More than the medical record constitutes, conversations, whether in a formal or informal setting, email, faxes, and letters are other potential sources of confidential member information.

Member confidentiality must be maintained at all times when providing health care services and during claims processing.

## HIPAA Security & Submitting PHI/Medical Records to MHC

Providers are expected to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers should recognize that identity and medical theft is a rapidly growing problem in the healthcare industry and that patients trust their health care providers to keep their most sensitive information private and confidential.

## Member Satisfaction Survey

MHC, or the State of California, conducts an annual satisfaction survey of its Medi-Cal Members. The National Committee for Quality Assurance (NCQA) Consumer Assessment of Health Plans Survey (CAHPS) is conducted annually. NCQA translates the survey into English and Spanish only. It is not available in other languages. MRMIB (Managed Risk Medical Insurance Board) conducts an annual survey similar to CAHPS.

The purpose of the surveys is to gather information from members regarding their perception of the health plan, their health care, Providers/Practitioners, access to care, and health plan customer service. The data is used to identify systemic issues that need to be addressed. The annual survey results are communicated in the MHC physician newsletter and posted on MolinaHealthcare.com.

# 9. APPEALS AND GRIEVANCES/COMPLAINTS

## Grievances and Appeals

What to do if you receive a:

- Pre-service or prior authorization denial for lack of information: Resubmit the request within 30 days of denial date, to UM with the UM requested additional information
- Pre-service or prior authorization denial for lack of medical necessity, failure to meet criteria, or non- benefit: by contacting the MHC Member Services Department at (888) 665-4621
- Post-service or retrospective authorization denial: Appeal on behalf of the member by contacting the MHC Member Services Department at (888) 665-4621. A request for retrospective review must be submitted to MHC within sixty (60) days of the service being provided
- Payment denial for any reason except for an unclean claim: Appeal your payment denial within three hundred sixty-five (365) days using the dispute resolution process
- Non-payment for an unclean claim: Submit a clean claim within the noted timeframe and with the information that is requested in the remit message

This section addresses the identification, review, and resolution process for four distinct topics:

- Provider/Practitioner Appeal (related to an authorization determination)
- Provider Disputes-Title 28, CCR, Section 1300.71.38 (related to provider claims appeals)
- Member Appeals (related to an authorization determination)
- Member Grievance [related to a Potential Quality of Care (PQOC) issue]

More information regarding PQOCs may be obtained by contacting MHC's Quality Improvement Department at (800) 526-8196, ext. 126137.

## Provider Claim Disputes – The "Appeals Process"

A Provider/Practitioner grievance or complaint is described in Title 22, California Code of Regulations (CCR), as a written entry into the appeals process. Molina maintains two types of appeals:

- Appeals regarding non-payment or processing of claims known as Provider Disputes

A Provider/Practitioner of medical services may submit to Molina an appeal concerning the modification or denial of a requested service or the payment processing or non-payment of a claim by the Plan. Molina will comply with the requirements specified in Section 56262, of Title 22 of the CCR, and Title 28, CCR, Section 1300.71.38.

## Claims Settlement Practices and Provider Dispute Resolution.

Appeals regarding modifications or denial of a pre-service request are considered Member appeals.

## Provider Disputes

A Provider Dispute is defined as a written notice prepared by a provider that:

- Challenges, appeals, or requests reconsideration of a claim that has been denied, adjusted, or contested
- Challenges MHC's request for reimbursement for an overpayment of a claim
- Seeks resolution of a billing determination or other contractual dispute

For claims with dates of service in 2004 or after, all provider disputes require the submission of a Provider Dispute Resolution Request Form or a Letter of Explanation, which serves as a written first level appeal by the provider. For paper submission, MHC will acknowledge the receipt of the dispute within 15 working days and within two working days for electronic submissions. If additional information is needed from the provider, MHC has 45 working days to request necessary additional information. Once notified in writing, the provider has 30 working days to submit additional information, or the claim dispute will be closed by MHC.

Providers may dispute by submitting and completing a Provider Dispute Resolution Request Form within 365 days from the last date of action on the issue. A written dispute form must include the provider's name, identification number, and contact information, date of service, claim number, explanation for the dispute and all required documentation or proof to support the dispute. Disputes with incomplete information and missing required documentation will not be processed. Molina allows two resubmissions of a claim dispute.

How to Submit Provider Disputes:

Method 1: Molina Availity Essentials portal (most preferred method):

- Log onto Availity Essentials portal: provider.MolinaHealthcare.com
- Search and identify adjudicated claim and submit a dispute/appeal
- Complete required information on the portal and upload required documents or proof to support the dispute

Method 2: Fax to (562) 499-0633

Method 3: Mail to:

Molina Healthcare of California
Attn: Provider Dispute Resolution Unit
P.O. Box 22722
Long Beach, CA 90801

## Provider Claim Disputes/Appeals Involving Shared Risk Capitated IPAs/Medical Groups

If an appeal involves a Member who is assigned to a Primary Care Practitioner (PCP) or IPA/Medical Group under a shared-risk capitated compensation agreement, Molina will delegate the first level of claim dispute/appeal to the IPA/Medical Group. Molina does not delegate the second level dispute/appeals. However, Molina will make the final determination on all claim disputes/appeals received from Providers/Practitioners.

All first level disputes/appeals should be mailed directly to the participating IPA/Medical Group. All first level disputes/appeals received by Molina will be forwarded to the IPA/Medical Group upon receipt. The IPA/Medical Group will acknowledge receipt of the appeal, review the appeal and make an accurate determination within the regulatory timeframes,

If the decision is to overturn the original claim denial, the IPA/Medical Group will respond to the Provider/ Practitioner and pay the claim and any interest, where applicable. If the determination is to continue to uphold the denial, the Provider/Practitioner may appeal the first level claim dispute/appeal decision by submitting an appeal to Molina or its affiliated health plan for a second level dispute/appeal determination. If Molina upholds the denial, the Provider/Practitioner will be notified of the second level dispute/appeal decision at that time.

## Balance Billing

MHC prohibits Providers/Practitioners from balance-billing a Member when the denial disputed is upheld. The Provider/Practitioner is expected to adjust off the balance owed if the denial is upheld in the appeals process.

## Member Appeals

A Provider/Practitioner on behalf of a member may appeal a Utilization Management decision to deny or modify a requested service.

### Member Appeals Process

If the Member or Provider/Practitioner on behalf of a Member is dissatisfied with an adverse authorization decision, he or she may initiate an appeal by telephone, fax, in writing, or on MHC's website, E-mail, or mail within 60 calendar days after the Member's receipt of the denial or modification letter.

Providers/Practitioners may refer members to MHC's website for additional information on how to file a Member grievance. Contact the department noted below, Monday through Friday between 7:00 a.m. and 7:00 p.m.:

Molina Healthcare of California
Attn: Member Appeals and Grievance Department
200 Oceangate, Suite 100
Long Beach, CA 90802

Tel: (888) 665-4621
Hearing Impaired: (TTY/TDD) 711
Fax: (562) 499-0757

www.MolinaHealthcare.com

## Standard (30-day) and Expedited (72-hour) Appeal Processes

Health plans have 30 days to process a standard appeal. In some cases, members have the right to an expedited, 72-hour appeal. Members can get a faster, expedited appeal if the member's health or ability to function could be seriously harmed by waiting for a standard appeal. If a member requests an expedited appeal, the health plan will evaluate the member's request and medical condition to determine if the appeal qualifies as an expedited, 72-hour appeal. If not, the appeal will be processed within the standard 30 days.

*(The following sections indicated with an asterisk were extracted verbatim from the Medi-Cal Program Evidence of Coverage Guide for Providers/Practitioners to understand Independent Medical Review as explained to the members).

## Independent Medical Review (IMR)

If you want an IMR, you must first file an appeal with your health plan. If you do not hear from your health plan within 30 days, or if you are unhappy with your health plan's decision, then you may then request an IMR. You must ask for an IMR within 180 days from the date of the "Notice of Appeal Resolution" letter.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-888-665-4621, TTY users call: 711 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical

services. The Department also has a toll-free telephone number (888-466-2219) and a TDD line (877-688- 9891) for the hearing and speech impaired. The Department's Internet Website: www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online.

## Department of Managed Healthcare Services (DMHC) Assistance

### State Hearing

If you want a State Hearing, you must ask for one within 120 days from the date of the "Notice of Appeal Resolution" letter. You can ask for a State Hearing by phone or in writing:

- By phone: Call 800-952-5253. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 800-952-8349
- In writing: Fill out a State Hearing form or send a letter to:
  California Department of Social Services State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430
- Be sure to include your name, address, telephone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one
- After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within three working days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an "expedited hearing" and provide the letter with your request for a hearing

You may speak at the State Hearing yourself. Or someone like a relative, friend, advocate, doctor, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an "authorized representative."

### External Independent Review

Experimental and investigational therapies may be denied when determined not to be medically necessary. However, California law entitles you to request and obtain an external independent review of that coverage decision through the independent medical review (IMR) process administered by the Department of Managed Health Care (DMHC) if your physician certifies that you have a life-threatening or seriously debilitating condition and further certifies that standard therapies have not been effective or do not exist with respect to your condition, or there is no more beneficial

therapy than the therapy proposed. If experimental and investigational therapies are denied, we will notify you within five days of your right to request and obtain an external independent review of that decision by an entity accredited by the State of California and you may contact MHC at (888) 665-4621 Monday through Friday, 7:00 a.m. to 7:00 p.m. for information on this subject.

External independent review of a denial of experimental or investigational therapies will be completed within 30 days of your request for review. However, if your physician determines that delay in the proposed therapy would be harmful if not promptly initiated, the external independent review may be expedited to provide a determination within seven days of your request for expedited review.

You will be eligible to participate in MHC's external independent review system to examine a coverage decision regarding experimental and investigational therapies if you meet all of the following eligibility criteria:

1. You have either:
   - A. A life-threatening condition, which includes either (1) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or (2) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival; or
   - B. A seriously debilitating condition, which means diseases or conditions that cause major irreversible morbidity; and
2. Your physician certifies that you have a condition, as defined in paragraph (1) above, for which standard therapies have not been effective in improving your condition, would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by MHC than the therapy proposed pursuant to paragraph (3) below; and
3. Either:
   - A. Your physician, who is under contract with or employed by MHC, has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to you than any available standard therapies, or
   - B. You, or your physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in subdivision (d) of Health and Safety Code Section 1370.4, is likely to be more beneficial for you than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require MHC to pay for the services of a nonparticipating physician provided pursuant to this subdivision, that are not otherwise covered pursuant to MHC contract; and you have been denied coverage by MHC for a drug, device, procedure or other therapy recommended or requested pursuant to paragraph (3) above; and

4. The specific drug, device, procedure or other therapy recommended pursuant to paragraph (3) above would be a covered service, except for MHC's determination that the therapy is experimental or investigational.

Please note that you will have the right to submit evidence in support of your request for external independent review. You should also be aware that the external independent review system does not replace MHC's grievance process. Rather, the external independent review system is available in addition to MHC's grievance process.

## Department of Health Care Services (DHCS) Assistance

The California Department of Health Care Services (DHCS) is available to provide assistance in investigating and resolving any complaints or grievances you may have regarding your care and services. If you wish to use the services of the DHCS to address your concerns, complaints, or grievances, please call the Medi-Cal Managed Care Ombudsman toll-free at (888) 452-8609, Monday through Friday, between 8:00 a.m. and 5:00 p.m. or dial 711 for TTY assistance.

### State Regulations Available

State regulations, including those covering state hearings, are available at the local office of the County Welfare Department.

### Authorized Representative

Members can represent themselves at the state hearing. They can also be represented by a friend, attorney, or any other person, but are expected to arrange for the representative themselves. Members can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response Unit (800) 952- 5253.

## Member Grievance

The Department of Managed Health Care (DMHC) has amended the California Knox-Keene Health Care Service Plan Act pertaining to health plan member grievance procedures. Under this amendment, health plans are required to distribute the Plan's Member Grievance Procedures and Member Grievance/Complaint Forms to participating Providers/Practitioners.

### Potential Quality of Care Issue (PQOC)

MHC recognizes that PQOCs may be identified through a multitude of inputs internally and externally, including Provider/Practitioner grievances or complaints and member grievances or complaints. For this reason, MHC's Quality Improvement Program includes input from both Provider Services and Member Services to identify both individual or incident specific PQOCs, as well as identifying specific trends.

## Member Grievance System

MHC Members' grievances are addressed through MHC's internal grievance process. A Member grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by MHC to make an authorized decision. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. MHC will investigate Member grievances, attempt to resolve the concerns, and take action as appropriate resolutions and findings are considered confidential and are privileged under California law. A Member must not be discriminated against because he/she has filed a Member grievance.

## Member Grievance Submission

Member grievances may be submitted to MHC verbally, via email, on the MHC website, or in writing. Members or the Provider/Practitioner on behalf of the member may call the MHC Member Services Department for assistance in lodging a grievance. Members may obtain a complaint form from their Primary Care Practitioner's (PCP's) office, the MHC website, or they may call the MHC Member Services Department to receive these forms. Once the Member grievance is received by the Member Services Department, the grievance is submitted to the appropriate departmental contact for investigation.

MHC will provide the Member with written notification acknowledging the Member grievance within five working days of its receipt. The Member will be informed in writing of the proposed resolution or outcome of the grievance within 30 days.

It is important to note that a Member grievance may be a potential quality of care or service issue and PCPs, as well as their office staff, should be ready to assist a Member with needed information. As a PCP, you must have MHC grievance forms in your office conveniently located for your Members or they can also be found on the MHC website. If you need to order grievance forms, please contact MHC's Provider Services department at: (855) 322-4075.

Member complaints may include, but are not limited to:

- Excessive waiting time in a Provider/Practitioner's office
- Inappropriate behavior and/or demeanor (PCP's/Office Staff's)
- Denied services. Clinical grievance subject to member/Provider/Practitioner appeal of the UM decision and expedited appeal of the UM decision
- Inadequacy of the facilities, including appearance
- Any problem that the member is having with MHC or their IPA/Medical Group, contracted Providers/Practitioners
- Members billed for covered services

# 10. HEALTHCARE SERVICES: UTILIZATION MANAGEMENT

## Introduction

Health Care Services is comprised of Utilization Management and Care Management 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 using processes designed 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 review 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. Molina's UM program 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
- 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 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 qualified health care professionals perform all components of the UM and CM processes
- Ensuring UM decision making tools are appropriately applied in determining medical necessity decision

## Key Functions of the UM Program

The key functions of the UM program are listed below:

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

For more information about Molina's UM program, or to obtain a copy of the HCS Program description, clinical criteria used for decision making, and how to contact a UM reviewer, access the Molina website or contact 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.

## UM Decisions

A decision is any determination made by Molina or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination)
- Determination to delay, modify, or deny authorization or payment of request (adverse determination)
- Discontinuation of a payment or authorization for a service;

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 are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal 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 authorization of services to a Member.

Providers can contact Molina's Healthcare Services department at: (844) 557-8434 to obtain Molina's UM Criteria.

Where applicable, Molina Corporate Policies can be found on the public website at: www.MolinaClinicalPolicy.com. Please note that Molina follows state-specific criteria, if available, before applying Molina-specific criteria.

## Medical Necessity

"Medically Necessary" or "Medical Necessity" is defined under Title 22, California Code of Regulations, Section 51303(a) as "health care services …which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury..." In any of those circumstances, if a patient's condition produces debilitating symptoms or side effects, then it is also considered medically necessary to treat those.

This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury or disease; and,
3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

The fact that a Provider has prescribed, recommended, or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

## MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Molina has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity Essentials portal. With MCG Cite for Guideline Transparency, Molina can share clinical indications with Providers. The tool operates as a secure extension of Molina's existing MCG investment and helps meet regulations around transparency for delivery of care:

- Transparency—Delivers medical determination transparency.
- Access—Clinical evidence that payers use to support member care decisions.
- Security—Ensures easy and flexible access via secure web access.

MCG Cite for Guideline Transparency does not affect the process for notifying Molina of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

Molina has also partnered with MCG Health, to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging prior authorization (PA) requests.

Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24 hours per day/7 days per week. This method of submission is strongly encouraged as your primary submission route, existing fax/phone/email processes will also be available. Clinical information submitted with the PA will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

**What is Cite AutoAuth and how does it work?**

By attaching the relevant care guideline content to each PA request and sending it directly to Molina, health care providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs, PET scans. To see the full list of imaging codes that require PA, refer to the PA code Look-Up Tool at MolinaHealthcare.com.

## 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 nationally

recognized evidence-based guidelines, third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

### 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. The Clinical review includes medical necessity and level of care.

All UM requests that may lead to a medical necessity adverse determination 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.

### Clinical Information

Molina requires copies of clinical information be submitted for documentation. Clinical information includes but is not limited to: physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina does not accept clinical summaries; telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations allows 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. The Molina prior authorization matrix of codes that require prior auth is customarily updated quarterly, but may be updated more frequently as appropriate, and is posted on the Molina website at: MolinaHealthcare.com, Frequently Used Forms.

Providers are encouraged to use the Molina prior authorization form provided on the Molina web site. 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, including address and NPI number).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.

- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested service is required including:
  - Pertinent medical history (include treatment, diagnostic tests, examination data).
  - Requested length of stay (for inpatient requests).
  - Rationale for expedited processing, if requested.

Services performed without authorization that require prior authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care post-service as part of its payment integrity process. Molina does not routinely retroactively authorize services that require a PA.

Sometimes the only provider who can render the appropriate services for a member is a non-contracted provider. All such services require prior authorization unless the service is provided as an emergency. Elective services provided by non-contracted providers need prior authorization, and then the arrangement of a single use/letter of agreement with Molina. If such services are rendered without prior authorization but were done so on an urgent/emergent basis, they will be reimbursed by Molina at standard Medi-Cal rates.

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 processing the request in the standard time frame could seriously jeopardize the life or health of the Member, the 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 Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited organization determinations/pre-service authorization requests, Molina will make a determination as promptly as the Member's health requires and no later than contractual and regulatory requirements after we receive the initial request for service whenever a provider indicates, or if we determine, that a standard authorization decision timeframe could jeopardize a Member's life or health. For a standard authorization request, Molina makes the determination and provides notification no later than contractual requirements.

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (844) 557-8434.

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 via fax.

## Peer-to-Peer Review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five business days of the decision. When at all possible, the Molina Medical Director who made the initial denial decision will be available to discuss the case with the Provider.

A "peer" is considered a physician, physician assistant, or nurse practitioner who is directly providing care to the Member. Contracted external parties, administrators, or facility UM staff can request that a peer-to-peer telephone communication be arranged and performed. However, in general, they are not the typical "peer" with whom Molina's Medical Director communicates to discuss a case.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and ID#
- Auth ID#
- Requesting Provider Name and contact number, best times to call

If a Medical Director is not immediately available, the call will be returned within two business days. Every effort will be made to return calls as expeditiously as possible.

## 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, please refer to the Prior Authorization tools located on the MolinaHealthcare.com website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix
- Prior Authorization Guide

**Availity Essentials portal:** Participating Providers are encouraged to use the Molina **Availity Essentials portal:** For prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Molina

Availity Essentials portal. The benefits of submitting your prior authorization request through the Availity Essentials portal are:

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

**Fax**: The Prior Authorization Request Form can be faxed to Molina at: (800) 811-4804.

**Phone**: Prior authorizations can be initiated by contacting Molina's Healthcare Services department at (844) 557-8434. It may be necessary to submit additional documentation before the authorization can be processed.

## Open Communication about Treatment

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

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

## 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 by calling (844) 557-8434 during normal business hours, Monday through Friday (except for holidays) from 8:30 a.m. to 5:30 p.m. 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 Availity Essentials portal for UM access.

Molina's Nurse Advice Line is available to Members 24 hours a day, seven days a week at: (888) 275-8750 Molina's Nurse Advice Line may handle after-hours UM calls.

## Emergency Services

Emergency Services means: Emergency Services are covered inpatient and outpatient services provided to address an Emergency Medical Condition that are furnished by a provider qualified to furnish emergency services and are needed to evaluate or stabilize an Emergency Medical Condition. Emergency Services include ambulance services dispatched through 911 or local equivalents. Emergency Services are those services that are urgently needed to evaluate or stabilize an Emergency Medical Condition.

An Emergency Medical Condition means 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: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of any bodily organ or part, or (d) serious disfigurement.

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.

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

Molina also provides Members a 24-hour Nurse Advice Line for medical advice. 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. An out-of-network emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a participating facility. Services provided after stabilization in a non-participating facility are not covered unless authorized by Molina.

Members over-utilizing the emergency department will be contacted by Molina Case Managers to provide assistance whenever possible and determine the reason for frequent use of Emergency Services.

Case Managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

## Inpatient Management

### Elective Inpatient Admissions

Molina requires prior authorization for all elective/scheduled inpatient admissions and procedures 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 (LOC), 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 admission notification, medical necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay.

### 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 are not Covered Services, unless Law or Government Program requirements mandate otherwise.

### Inpatient/Concurrent Review

Molina performs concurrent inpatient review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within 24 hours of the request.

Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an acute inpatient, when the clinical record supports the medical necessity for admission/continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and that the observation level of care has failed. Upon discharge the Provider must

provide Molina with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

### Inpatient Status Determinations

Molina's UM staff follow CMS and California guidelines to determine if the collected clinical information for requested services are "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain" by meeting all coverage, coding and medical necessity requirements (refer to the Medical Necessity section of this 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 work closely with the hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review 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 when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

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 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 for the first admission;
  - 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
- Certain chronic conditions for which subsequent Readmissions are often either not preventable or are expected to require significant follow-up care
- Neonatal and obstetrical Readmissions
- Initial admissions with a discharge status of “left against medical advice” because the intended care was not completed
- Behavioral Health readmissions
- Transplant related readmissions

## 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; in these cases, 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, regulation, guidance and evidence-based criteria sets.

Specific Federal or State requirements or Provider contracts that prohibit administrative denials supersede this policy.

## Affirmative Statement about Incentives

All medical decisions are coordinated and rendered by qualified physicians and licensed 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 and all its UM staff do 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 or other coverage arrangements.

## 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 by calling 844-557-8434 during normal business hours, Monday through Friday (except for Holidays) from 8:30 a.m. to 5:30 p.m. 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 Availity Essentials portal: provider.MolinaHealthcare.com

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

## 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 prior authorized by Molina. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations.

## Avoiding Conflict of Interest

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

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

## Coordination of Care and Services

Molina HCS staff 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.

Molina staff assists Providers by identifying needs and issues that may not be verbalized by Members, assisting to identify resources such as community programs, national support groups, and appropriate specialists and facilities. Molina also works collaboratively with providers to identify best practices 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.

## Continuity of Care and Transition of Members

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

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

For additional information regarding continuity of care and transition of Members, please contact Molina at: (844) 557-8434.

## Continuity and Coordination of Provider Communication

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

## Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is 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 themself, or unable to protect themself 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.

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

**Child Abuse**

California Department of Social Services: https://www.cdss.ca.gov/reporting/report-abuse/child-protective-services/report-child-abuse

Imperial County:
(760)-337-7750

Los Angele County:
(800)-540-4000 – Within CA
(213)-639-4500 – Outside CA
(800)-272-6699 – TDD
Online Reporting: https://reportchildabusela.org/

Riverside County:
(800)-442-4918
(877)-922-4453

Sacramento County:
(916)-875-5437

San Bernardino County:
(909)-384-9233
(800)-827-8724

San Diego County:
(858)-560-2191
(800)-344-6000

**Adult Abuse**

Imperial County:
Adult Protective Services
Phone: (760) 337-7878
https://www.co.imperial.ca.us/districtattorney/elder-abuse.html

San Bernardino County:
24-HOUR TOLL-FREE HOTLINE
1-877-565-2020
http://hss.sbcounty.gov/daas/programs/APS.aspx

San Diego County:
Adult Protective Services
Phone: (800) 339-4661
Online submission:
www.AISWebReferral.org
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/ais/adult_protective_services.html

Sacramento County:
3701 Branch Center Road
Sacramento CA 95827
Phone: (916) 874-9377
Fax: (916) 854-9341
https://dcfas.saccounty.net/SAS/Pages/Adult-Protective-Services/SP-Adult-Protective-Services.aspx

Los Angeles County:
24-Hour Abuse Hotline: (877) 477-3646
General Information, toll free in LA & Vicinity: (888) 202-4248
APS Mandated Reporter Hotline: (877) 477-3646 or (877) 4-R-Seniors - M-F, 8:30-5:00
https://wdacs.lacounty.gov/programs/aps/

Riverside County:
**DPSS – Adult Services Central Intake Center**
4060 County Circle Drive
Riverside, CA 92503
Hotline: 1-800-491-7123
Fax: 1-951-358-3969
http://dpss.co.riverside.ca.us/adult-services-division/adult-protective-services

Molina's HCS teams will work with PCPs and Medical Groups/IPAs 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 who 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 HealthCare Services Committee and the proper State agency.

## PCP Responsibilities in Care Management Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with the Member's individualized care plan (ICP), interdisciplinary care team (ICT) updates, and information regarding the Member's progress through the ICP when requested by the PCP. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

## Case Manager Responsibilities

The case manager collaborates with the Member and all resources involved in the Member's care to develop an ICP that includes recommended interventions from Member's interdisciplinary care team (ICT). ICP interventions include links to appropriate institutional and community resources, to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the case manager, Providers and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the case manager:

- Assesses the Member to determine if the Members' needs warrant care management.
- Monitors and communicates the progress of the implemented ICP to the Member's ICT, as Member needs warrant.

- Serves as a coordinator and resource to the Member, their representative and ICT participants throughout the implementation of the ICP, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program.

### Health Management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members. Level 1 Members can be engaged in the program for up to 60 days depending on Member preferences and the clinical judgement of the Health Management team.

### Level 1 Health Management

Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk assessments and Identification and Stratification. You can also directly refer Members who may benefit from these program offerings. Members can request to be enrolled or disenrolled in these programs at any time. Our Molina My Health programs include:

- Living with Asthma
- Living with Diabetes
- Living with High Blood Pressure
- Living with Heart Failure (HF)
- Living with COPD
- Living with Depression
- Weight Management
- Tobacco Cessation
- Nutrition

For more information about these programs, please call (866) 891-2320, or (TTY/TDD at 711 Relay).

### Maternity Screening and High-Risk Obstetrics

Molina offers to all pregnant members prenatal health education with resource information as appropriate and screening services to identify high risk pregnancy conditions. Care managers with specialized OB training provide additional care coordination and health education for members with identified high risk pregnancies to assure best outcomes for members and their newborns during pregnancy, delivery and through their sixth week post-delivery. Pregnant member outreach, screening, education and care management are initiated by provider notification to Molina, member

self-referral and internal Molina notification processes. Providers can notify Molina of pregnant/ high risk pregnant members via faxed Pregnancy Notification Report Forms.

### Health Education/Disease Management

Molina offers programs to help our Members and their families manage a diagnosed health condition. You as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Obesity
- Weight Management
- Smoking Cessation
- Organ Transplant
- Serious and Persistent Mental Illness (SPMI) and Substance Use Disorder
- Maternity Screening and High-Risk Obstetrics

### Pregnancy Notification Process

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at: MolinaHealthcare.com) within one working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Molina at (855) 556-1424.

### Member Newsletters

Member Newsletters are posted on the MolinaHealthcare.com website at least two times a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

### Member Health Education Materials

Members can access our easy-to-read evidenced-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression, and other relevant health topics identified during our engagement with Members. Materials are available through the Member Portal, direct mail as requested, email, and the My Molina mobile app.

### Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Molina Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the Member opts out. Identified Members will receive targeted

outreach such as educational materials, telephonic outreach or other materials to access information on their condition. The program model provides an "opt-out" option for Members who contact Molina Member Services and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include the following:

- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim with a relevant CMS accepted diagnosis or procedure code;
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Member Assessment calls made by staff to identify needs the member may have.
- Provider referral;
- Nurse Advice referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication.

## Provider Participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease
- Clinical resources such as patient assessment forms and diagnostic tools
- Patient education resources
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Case Management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on health management programs is available from your local Molina Healthcare Services department.

## 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 Members are required to see a PCP who is part of the Molina Network. Molina's 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. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.

## Care Management (CM)

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

The Molina care managers may be licensed professionals and are educated, trained and experienced in Molina's ICM program. The ICM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina care manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina care manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

## Referral to Care Management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the CM program. The case manager works collaboratively with all Members of the integrated care team (ICT), including the PCP, hospital UM staff, discharge planners, specialist Providers, ancillary Providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the Member being referred.

Members with the following conditions may qualify for Care Management and should be referred to the Molina ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births

- High-technology home care requiring more than two weeks of treatment
- Member accessing Emergency Department services inappropriately
- Children with Special Health Care Needs

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

Phone: (833) 234-1258
Fax: (562) 499-6105
Email: MHCCaseManagement@MolinaHealthCare.Com

## Key Functions of the UM Program

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

| Activity | Resource Management | Evaluation |
|---|---|---|
| Inpatient Admission Review | Eligibility verification<br><br>Prior authorization of planned elective admissions<br><br>Urgent/Emergent inpatient admission | Utilization data analysis |
| Prior Authorization Review | Eligibility verification<br><br>Benefit administration and interpretation.<br><br>Verification of current provider contract status.<br><br>Redirection of services to participating providers.<br><br>Medical necessity review of requested services to meet member need & benefit plan provisions. | Utilization data analysis<br><br>Geo-access analysis by Provider Contracting |
| Post-Service Claim Audits | Ensure authorized care meets member need and benefit plan provisions | Utilization data analysis. Monitoring for over and under-utilization of clinical resources |
| Discharge Planning | Ensure safe and effective transition from inpatient or facility-based care to a lower level of care | Utilization data analysis, including hospital readmission rates |

| Activity | Resource Management | Evaluation |
|---|---|---|
| Transitions of Care | Coordinate and facilitate Immediate post-hospital discharge and service needs including follow-up appointments | Analyze re-admission data |
| Care Management | Manage members with complex care needs and services.<br><br>Ensures appropriate level of care and services is achieved for optional health outcomes | Monitor utilization data.<br><br>Satisfaction of the care management process with quality surveys, member and provider input. |

## Specialty Pharmaceuticals/Injectables and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization. In some cases, they will be made available through a vendor, designated by Molina. More information about our Prior Authorization process is available in the Medical Management Program section of this Provider Manual.

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

Newly FDA approved drugs are considered non-formulary and subject to non-formulary policies and other non- formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee.

## Transitions of Care (ToC) Program

Transitions of Care staff work collaboratively with both Members and providers to ensure the coordination and continuity of care from one care setting to another as the Member's health status changes. This is accomplished by providing Members with the tools and support that promote knowledge and self-management of their condition, and by facilitating improved Member and provider understanding of roles, expectations, schedules and goals. Such transitions occur, for example, when a Member moves from a home to a hospital as the result of an exacerbation of chronic conditions or moves from a hospital to a rehabilitation facility after surgery.

MHC stresses the importance of timely communication between providers involved in a Member's care. This is especially critical between specialists, including behavioral

health providers, and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

MHC's ToC program is delivered in one of two ways:

- Transitions of Care Telephonic Coaching Program is designed to reach a large volume of high-risk Members by making an inpatient hospital outreach call and three or more subsequent phone calls within a four to six week period of time from the date of the Member's initial admission
- Healthcare Transitions Program is designed for Members to receive face-to-face contact with ToC staff – one time in the hospital prior to discharge and/or one time at home within two business days of discharge, targeted at members known to have admitting diagnoses which research has shown have the highest risk for readmission to an in-patient facility

The aims of the ToC programs include: preventing avoidable hospital readmissions, optimal transitioning from one care setting to another and/or identifying an unexpected change in condition requiring further assessment and intervention. Continuity of care post discharge communications may include, but not be limited to, phone calls and follow up letters to Members and their Primary Care Physicians (PCPs), specialty providers, other treating providers/practitioners as well as agencies providing long term services and supports (LTSS).

Transitions of Care staff function as a facilitator of interdisciplinary collaboration across the transition, engaging the Member, caregivers and providers to participate in the formation and implementation of an individualized care plan including interventions to mitigate the risk of re-hospitalization. The primary role of the transitions staff is to encourage self-management and direct communication between the Member and provider rather than to function as another health care provider.

For the face-to-face program, initial contact between the transitions staff and Member will be made during the inpatient stay. The MHC transitions staff will perform introductions, explain the program and describe the Member's role within the program. The Member may elect at this point not to participate in the program. For those who wish to continue, the transitions staff will verify the provider, Member address and telephone number, and provide the Member with MHC care transitions information, including contact information to access their MHC representative. All Members also receive the toll-free Nurse Advice Line phone number to call if they have questions or concerns after hours and also a toll- free phone number to call when their assigned coach is not readily available to reach them. When calling this number, the Member will either be immediately assisted with their needs by another ToC Coach or if they choose, a message will be sent to their assigned ToC Coach to contact them. The toll-free phone number is (844) 203-4287 and the hours of operation are 8:30 a.m. to 5:30 p.m., Monday through Friday.

The transitions staff will assist in coordinating the Member's discharge plan, which may include authorizing home care services or assisting the Member with after-treatment and therapy services.

The transitions staff also receives training in community resource referrals and will assist the Member when needed with referrals for items such as food, transportation and long-term services and supports. The ToC Program fits within MHC's Integrated Care Management Model, which promotes whole-person care. As the transitions program nears completion, if it is determined the Member has ongoing needs, the ToC coach will refer the Member to the Case Management and/or the PCP so that the Member can receive further assessment and interventions to address those needs going forward.

# 11. HEALTHCARE SERVICES: CASE MANAGEMENT & LONG-TERM SERVICES AND SUPPORTS (LTSS)

The Molina Case Management (CM) Program is an integral part of the comprehensive Medical Management Program. The goal of case management is to improve the health and well-being of members, particularly those members with serious, debilitating or complex medical conditions by educating, assisting, and facilitating access to the most appropriate health care services available so that they may regain optimum health or improved functional capability, in the right settings and in a cost-effective manner. Case management involves assessment of the member's condition; determination of available benefits and resources; collaboration between Molina and providers and the development and implementation of an individualized, multidisciplinary case management plan with performance goals, monitoring and follow-up. It is the responsibility of contracted providers to assess members and with the participation of the member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

MHC's practitioners/providers are an integral part of the Case Management Program. The state of California requires that Primary Care Providers and Molina provide Comprehensive Medical Case Management to each member. These services are provided by the Primary Care Provider (PCP) in collaboration with Molina to ensure the coordination of medically necessary health care services including waiver program or carved out services, the provision of preventive services in accordance with established standards and periodicity schedules, and continuity of care for members. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs. The extent of collaboration with the plan is based on the needs identified by the PCP which could include but is not limited to coordination with Care Access & Monitoring staff for authorizations, Secure Transportation for non-medical transportation services, or Case Management staff for additional support in care coordination.

The Molina case managers are professionals and are educated, trained and experienced in the case management process. The CM program is based on a member advocacy philosophy, designed and administered to assure the member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. Molina staff assists providers by identifying needs and issues that may not be verbalized by providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with providers and members to ensure efforts are efficient and non-duplicative.

Based on the needs of the member, Comprehensive Medical Case Management services are described as either Basic or Complex:

- Basic Case Management services are provided by the primary care provider in collaboration with the Plan and include:
  - Initial Health Assessment (IHA).
  - Identification of appropriate providers and facilities to meet member care needs (such as medical, rehabilitation, and support services).
  - Direct communication between the provider and member/family.
  - Member and family education, including healthy lifestyle changes when warranted.
  - Coordination of carved out and linked services, and referral to appropriate community resources and other agencies, including but not limited to California Children's Services (CCS), Regional Centers, In Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), etc.
  - Complex Case Management services are provided by the primary care provider, in collaboration with the Plan, and include:
    - Basic Case Management Services (described above).
    - Management of acute or chronic illness, including emotional and social support issued by a multidisciplinary case management team.
    - Intense coordination of resources to ensure member regains optimal health or improved functionality.
    - With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually.
    - Services for Seniors and Persons with Disabilities (SPD) beneficiaries must include the concepts of Person-Centered Planning.

## Identifying Members for Case Management

All Members receive Basic Case Management services from the PCP with varying collaboration from the Plan based on the Member's needs. For members who need greater involvement from Plan case management staff (such as Members with Medicare and Medi-Cal and Seniors & Persons with Disabilities), Molina proactively identifies members who need Case Management from MHC using a variety of clinical care processes and data sources including but not limited to utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical and administrative data (claims data, encounter data, hospital admission/discharge data, pharmacy data obtained from Pharmacy Benefit Management (PBM) organization and/or State, data collected through the Care Access and Monitoring (CAM) process (including prior authorization data, concurrent review data), laboratory results, reinsurance reports, frequent emergency department (ED) use reports and/or predictive modeling software programs/reports), and any other available data. In addition, MHC's case management software platform system contains a rules engine that identifies and stratifies members that are appropriate candidates for CM through system-based rules that consider certain medical conditions, utilization, claims, pharmacy, and laboratory data.

In addition, Molina provides multiple avenues for members to be referred to the Plan for case management services beyond what the PCP provides, including telephone, fax or Phone.

Phone: (833) 234-1258
Fax: (562) 499-6105
Email: MHCCaseManagement@MolinaHealthcare.com

Molina welcomes referrals from PCPs, hospital discharge planners, social workers, CCS case managers, Early Start staff, members and/or member's family/caregiver, specialty physician, and other practitioners. CM Program and contact information is also available from Member Services, 24-hour Nurse Advice Line and in the Health Care Professionals sections on the Molina website.

Members appropriate for Complex Case Management are those who have complex service needs and may include your patients with multiple medical conditions, high level of dependence, conditions that require care from multiple specialties and/or have additional social, psychosocial, psychological and emotional issues that exacerbate the condition, treatment regime and/or discharge plan.

## PCP Responsibilities in Case Management Referrals

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

## Case Manager Responsibilities

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

- Monitors and communicates the progress of the implemented plan of care to all involved resources.
- Serves as a coordinator and resource to team members throughout the implementation of the plan and makes revisions to the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-help.
- Monitors progress toward the Member's achievement of treatment plan goals in order to determine an appropriate time for the Member's discharge from the CM program.

## Assessment and Leveling

Members who have been identified for CM by MHC are assigned to the appropriate Molina staff. New cases are prioritized and managed according to urgency. The staff

reviews all available information (such as the source and reason for referral, utilization data, etc.) and contacts the member by telephone to perform an assessment.

Members have the right to decline participation or to disenroll from the CM program at any time. Molina Members are assumed to be in the program unless they opt out. However, members cannot opt out of the Basic Case Management provided by their PCP.

The assigned CM makes three attempts to reach the member by phone on different days and times. If the member cannot be reached, the CM will attempt to find other phone numbers (e.g. from PCP office, pharmacy, hospital face sheets, etc.). If no other phone numbers are found or those other numbers yield no contact, the CM sends an "unable to contact" letter. If appropriate, the CM may also refer the member to a Community Connector who will attempt to locate the member at the physical and mailing addresses on file in Molina's membership database. If the mail is not returned to Molina, the member does not contact Molina within 14 calendar days, and/or the Community Connector does not locate the member it will be assumed that the member does not desire CM.

During the first contact with the member by Molina staff, an initial assessment is completed or an appointment for completing the assessment is made. The initial assessment will be initiated as expeditiously as the member's condition requires and will be completed within 30 days of assignment. The assessment may be completed in multiple contacts. The assessment is conducted either telephonically, or during a home visit. Home visits are considered an enhancement to accurate assessment and will be made to provide a more accurate evaluation of the member and their circumstances and needs when deemed appropriate. Molina's CM process includes an assessment of the member's health status, including an evaluation of their medical, psychosocial and behavioral health situation and needs as well as condition-specific issues. The assessment provides the Molina case manager with the foundational information that is used to develop an individualized plan of care.

These assessments include the following elements based on NCQA, State and Federal guidelines:

- Health status and diagnoses
- Clinical history
- Medications prescribed
- Activities of daily living, functional status, need for or use of LTSS
- Cultural and linguistic needs
- Visual and hearing needs
- Caregiver resources
- Available benefits and community resources, including carved out and linked services such as behavioral health, substance abuse, long term supportive services, California Children's Services, Early Start, etc.
- Life-planning activities (e.g., healthcare power of attorney, advance directives)
- Smoking

- Readiness to change
- Member's desire / interest in self-directing their care
- Communication barriers with providers
- Treatment and medication adherence
- Emergency Department and inpatient use
- Primary Care Physician visits
- Living situation
- Psychosocial needs (e.g., food, clothing, employment)
- Durable medical equipment needs
- Health goals
- Mental health and
- Chemical dependency

Based on the on the member's responses to the initial health risk assessment, additional condition-specific health assessments may be used to determine what level/intensity of case management is needed. The case manager then works with the member to identify interventions that support member achievement of short- and long-term goals. For all levels, the focus of the interventions is to provide member education and/or to coordinate access to services which will lead to the most appropriate levels of care and utilization of health services while maintaining or improving the members' health and functioning.

| **Basic Case Management** | | | | |
|---|---|---|---|---|
| **Case Management** | | | **Complex Case Management** | |
| PCP + Molina Care Coordination | Level 1 Health Management | Level 2 Care Interventions | Level 3 Complex | Level 4 Intensive Need |

Once a determination has been made that the member will participate in case management, the Care Manager sends the member a welcome letter. A copy of the welcome letter is also sent to the member's primary care physician and any applicable specialty physicians.

The resulting care plan is approved by the member, may be reviewed by the Interdisciplinary Care Team (ICT) and maintained and updated by the Case Manager as the member's condition changes. The Case Manager also addresses barriers with the member and/or caregiver and collaborates with providers to ensure the member is receiving the right care, in the right setting, with the right provider.

The purpose of the HCS program interventions at all levels is to ensure that the member and/or family understands and agrees with the care plan, understands the member/family/physician/case manager role in fulfilling the care plan, key self-management concepts and has the resources for implementation. All member education is consistent with nationally accepted guidelines for the particular health condition.

### Level 1 – Health Management

Health Management is focused on disease prevention and health promotion. It is provided for members whose lower acuity chronic conditions; behavior (e.g., smoking or missing preventive services) or unmet needs (e.g., transportation assistance or home services) put them at increased risk for future health problems and compromise independent living. The goal is to achieve member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation throughout the continuum of care.

At this level, Members receive educational materials via mail about how to improve lifestyle factors that increase the risk of disease onset or exacerbation. Topics covered include smoking cessation, weight loss, nutrition, exercise, hypertension, hyperlipidemia, and cancer screenings, among others. Members are given the option, if they so choose, to engage in telephone-based health coaching with Health Management staff, which includes nurses, social workers, dieticians, and health educators.

### Level 2 – Case Management

Case Management is provided for Members who have medium-risk chronic illness requiring ongoing intervention. These services are designed to improve the Member's health status and reduce the burden of disease through education and assistance with the coordination of care including LTSS. The goal of Case Management is to collaboratively assess the Member's unique health needs, create individualized care plans (ICPs) with prioritized goals, and facilitate services that minimize barriers to care for optimal health outcomes. Case Managers have direct telephonic access with Members. In addition to the member, Case Management teams also include pharmacists, social workers and behavioral health professionals who are consulted regarding patient care plans. In addition to telephonic outreach to the member, the Case Manager may enlist the help of a Community Connector to meet with the Member in the community for education, access or information exchange.

### Level 3 – Complex Case Management

Complex Case Management is provided for Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the health care system to facilitate the appropriate delivery of care and services.

The goal of Complex Case Management is to help Members improve functional capacity and regain optimum health in an efficient and cost-effective manner. Comprehensive assessments of Member conditions include the development of a case management plan with performance goals and identification of available benefits and resources. Case Managers monitor, follow-up and evaluate the effectiveness of the services provided on an ongoing basis. Complex Case Management employs both telephonic and face-to-face interventions.

MHC continues to look for innovative ideas to promote health, for instance, MHC has implemented a Community Connector program. Community Connectors use a Community Health Worker model in order to support MHC's most vulnerable members within their home and community with social services access and coordination. They serve as patient navigators and promote health within their own communities by providing education, advocacy and social support.

### Level 4 – Intensive Needs

Level 4 focuses on Members with intensive needs who are at risk of an emergency department visit, an inpatient admission, or institutionalization, and offers additional high intensity, highly specialized services. These members often have been high utilizers of medical services. Members who may be candidates for organ transplant or who may be considered for other high-risk or specialized treatments are also placed into this level. Level 4 also includes those Members who are currently institutionalized but qualify to transfer to a home or community setting. These services are designed to improve Member's health status and reduce the burden of disease through education as described in Level 1.

If the Member's Level requires case management at a higher or lower level than the staff assigned can provide or the Member's needs require assignment to a staff person with particular subject matter expertise, the staff will discuss the findings with his/her supervisor so that the Member can be assigned accordingly. For example, if a Member is assessed by a case manager who is a RN with expertise in clinically complex conditions and the Member's needs are assessed to be primarily related to a behavioral health condition, the Supervisor would reassign the case to a case manager of an appropriate discipline with experience in behavioral health. Similarly, should a case manager with a Master's in Social Work assess a member with severe heart disease who is a candidate for transplant, the Supervisor would identify a case manager with the appropriate discipline and experience.

## Case Management Process / Development of a Plan of Care

The Member's PCP is the primary leader of the health team involved in the coordination and direction of care services for the Member. If the Member is receiving case management services from the PCP only, the plan of care is documented in the Member's medical record. The care plan is maintained in Molina's case management software platform "Clinical Care Advance (CCA)" and a copy is sent to the PCP for review and inclusion in the medical record.

An individualized plan of care is required for each Member using Person-Centered planning and treatment approaches that are collaborative and responsive to the Member's health care needs. Members can choose to include any family, friends and professionals to participate in discussions or decisions regarding treatments, services or other elements of the care plan. Specific activities and interventions tailored to the needs of the individual must be included, assuring consideration for the Member's or responsible party's goals, preferences and choices.

Care plans created by Molina staff in the CCA System contain Guidelines and Milestones that are used to identify member needs, actions related to those needs, desired outcomes and evaluation criteria. Guidelines in CCA are defined as a standard set of Goals and Milestones that reflect the best practices for a particular problem or diagnosis. Documentation from the Member assessment as well as a variety of other sources such as physician offices, facility medical records and discharge planners in other organizations etc. will be considered in the process of case management assessment and planning. Based on Member needs and preferences the case management staff will solicit input from a multidisciplinary team such as the Member's PCP, specialist physician, home health provider, CCS or Regional Center liaison, and Molina subject-matter experts such as pharmacist, dietitian, social worker or Medical Director.

Molina case management staff will:

- Ensure members receive all necessary information regarding treatment or services so that they may make informed choices
- Follow the appropriate process for services requiring authorization with clinical review
- Discuss the care plan and/or follow up activities with the member
- Create care plans that include:
  - Problems
  - Goals – An established target that a member should meet within a guideline/care plan. Complex cases contain at least one short-term goal and one long-term goal, and the goals must be prioritized and measurable. Progress towards goals is assessed at least quarterly
  - Interventions – Interventions provide the implementation of content developed to aid patients or practitioners; they may include phone calls, e-mails, mailings, coaching, home visits, advice, reminders and tools. Plans for continuity of care including transition of care and transfers are included and approaches to collaboration with family members, other Care Managers such as those from home health, hospice, acute or long-term care, physicians, etc. are included as appropriate
  - Outcome – The anticipated result of a planned intervention within a guideline in the care plan
  - Barriers – Barriers to care will be addressed including those relative to the Member's ability to achieve goals or to comply with their treatment plan. Such things as the Member's lack of understanding, ability to understand, motivation, financial need, insurance issues, transportation problems, lack of family or other caregiver support, inadequate or inappropriate housing, social and cultural issues/isolation, and so forth may be considered
  - Resources to be utilized, including level of care - Also included in the plan will be resources to be utilized such as the Complex Care Manager, Medical Care Manager, Social Worker, Disease Care Manager, Disease Management Program, education, cultural and linguistic services, etc. Plans for continuity of care including transition of care and transfers will also be included. Approaches to collaboration with family members, other Care Manager(s) such as those from

home health, hospice, acute or long-term care, physicians, waiver programs, state case workers, etc. will be included as appropriate
- Time frames/schedules for reevaluation - will be determined and documented in the case management plan. Member progress toward goals and overcoming barriers will be assessed and documented as frequently as needed and no less than quarterly. Plan goal adjustments will be made based on the unique and changing needs of the member and will consider such things as the Member's overcoming barriers to care and meeting their treatment goals. Ongoing assessment-reassessment, goal adjustment, and modification of the care plan are considered core case management activities and will be completed and documented in a timely manner. Such changes will be communicated to the member and / or caregiver and other collaborators
- Planning for continuity of care, including transition of care and transfers
- Collaborative approaches to be used, including family participation
- A schedule for follow-up and communication with the Member is documented within the care plan
- Member Self-Management Plan – The case manager will develop, document, and communicate a plan for Member self-management that may include such things as members' monitoring and daily charting of their symptoms, activities, weight, blood pressure, glucose levels, daily activity, and their compliance with dietary and/or fluid intake, dressing changes and other prescribed therapies. Focus will be on activities that are designed to shift the focus in patient care from members receiving care from a practitioner or care team to members providing care for themselves, where appropriate

The PCP will be invited and must be an active participant in the Member's Interdisciplinary Case Team (ICT). Each CM is responsible for sending the care plan to the member and their assigned PCP. We request that the PCP review every care plan and provide additional observations and information as appropriate to support the member's care coordination preferences and needs. All care plans whether they are authored by Molina staff and/or PCPs be clearly documented in the Member's medical records.

## Health Education and Disease Management Programs

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

## Referrals to State or County Case Management Programs

When a Member is identified as being eligible for a County or State supported health care program, an MHC Case Manager may assist the PCP to ensure timely referral to the appropriate program. The PCP, with the patient's/family's approval, makes the referral to the program. The PCP will coordinate primary medical care services for Members who are eligible.

## Case Management Process/Reassessment

The case management plan includes a schedule for reassessment of member progress towards overcoming barriers to care and goal achievement. Reassessment schedules depend on the complexity and/or stability of Member's situation. For example, if the Member has transitioned from one level of care to another or has experienced a significant medical (e.g. stroke) or life event (e.g. eviction leading to homelessness) that could impact their ability to manage their health. A schedule for follow-up, communication with the Member and reassessment is established by the case manager.

## Case Closure

The Member will remain in Case Management until one of the following occurs: Member has terminated/transferred membership from Molina; Member has expired, is unable to be reached or Member refuses or withdraws consent for case management. In addition, the member's goals can be met and as a result there are no active care coordination needs noted. The PCP and Member will be notified that the Member can re-engage with Molina case management staff if their condition changes and case management by health plan staff is needed again.

## Outcomes Evaluation/Measuring Effectiveness

MHC uses a variety of approaches to evaluate the effectiveness of the program. Member satisfaction with the MHC Case Management Program is measured at least annually via a survey of Members whose case management cases were closed or whose case is currently open to case management and have received services for a minimum of 60 days. The survey measures the overall program and the usefulness of case management services. Areas of survey measurement include Member's adherence to treatment plan, knowledge of condition, and appropriate service coordination. Member satisfaction is also measured via an analysis of member complaints related to the program. Utilization data such as admissions, ED visits and bed days and readmission rates per thousand per year are also analyzed. Process measures also look at average cases per case manager, referral sources and reasons, decline rates, etc.

# 12. HEALTHCARE SERVICES: WOMEN'S & ADULT HEALTH SERVICES, INCLUDING PREVENTIVE CARE

## Pregnancy and Maternity Care

All pregnant and postpartum women must be offered access to the Comprehensive Perinatal Services Program (CPSP) or equivalent services. This includes the multi-disciplinary integration of health education, nutrition, and psychosocial assessments. In addition, pregnant and postpartum women have access to medical/obstetrical care, genetic counseling, case coordination/case management, individualized care plan (ICP) development with updates, trimester reassessments, and postpartum assessment to include health education, nutrition and psychosocial assessments, and medical/obstetrical care to both the common and identified high-risk pregnancy/postpartum member within seven to 84 days postpartum.

### Provider/Practitioner Responsibilities

OB care Providers/Practitioners are strongly encouraged to be CPSP certified or have a formal relationship with a CPSP certified Provider/Practitioner for the provision of CPSP support services. All pregnant members shall be referred and assigned to CPSP certified Providers/Practitioners for CPSP services, whenever possible. The CPSP Providers/Practitioners shall be involved with the following:

- Integration of clinical health education, nutrition, and psychosocial assessment
- Medical obstetrical care, genetic counseling, and case coordination/management
- Use of appropriate documentation and care planning tools
- Submission of encounter and outcomes data

As of July 1, 2019, AB 2193 Maternal Mental Health requires a licensed health care practitioner who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. A health provider must use a validated tool to assess the member's mental health, either in the prenatal or postpartum period, or both. Two examples are the Patient Health Questionnaire-9 (PHQ-9) and the Edinburgh Postnatal Depression Scale (EPDS). Molina requires healthcare providers to document mental health screening for pregnant or postpartum members using the current CPT/HCPCS claim codes. Molina Maternal Mental Health Program guidelines and criteria are available upon request by contacting the Provider Contact Center.

### CPSP Certified Providers/Practitioners of Perinatal Services

- CPSP Certified Providers/Practitioners shall be responsible for providing and complying with all CPSP service requirements for their pregnant and postpartum members up to 60 days after delivery
- CPSP Certified Providers/Practitioners shall be responsible for complying with MHC's policy and procedure and Comprehensive Perinatal Services Program (CPSP) requirements and standards including use of appropriate assessment,

documentation, and care planning tools; submission of reporting forms (i.e. Pregnancy Notification Report)
- All CPSP Providers/Practitioners will receive information on how to obtain copies of CPSP's "Steps to Take" materials which provide helpful information to staff members to effectively assess, provide intervention for common pregnancy related conditions/ discomforts and how to appropriately refer pregnant members to all appropriate services

### Non-CPSP Certified Providers/Practitioners of Perinatal Services

Non-CPSP Providers/Practitioners must comply with MHC policy and procedures and standards including:

- Use of appropriate assessment, documentation, and care planning tools
- Submission of reporting forms (e.g., Pregnancy Notification Report)
- Employment of appropriate, qualified staff (e.g., CPHW)

MHC's Perinatal Services Staff may also perform audits/reviews on, but not limited to, the following:

- Member satisfaction questionnaire
- Member complaints

MHC and the Local Health Departments shall provide a consolidated effort to promote, encourage, and assist all Non-CPSP Providers/Practitioners in obtaining CPSP certification through the Department of Health Care Services. MHC and the Local Health Department shall provide ongoing support to all MHC contracted CPSP certified Providers/Practitioners.

Non-CPSP certified Providers/Practitioners may choose to outsource CPSP services. MHC Perinatal Services Staff shall provide technical assistance to Non-CPSP Providers/Practitioners in referring members to appropriate facilities (clinics, hospitals, etc.) as necessary. Non-CPSP certified Providers/Practitioners may refer their high-risk pregnancies to MHC's Motherhood Matters Program.

For more information on how to become a DHCS certified CPSP Provider/Practitioner, call the appropriate CPSP Program Coordinator:

- Imperial: (760) 482-2905
- Los Angeles: (213) 639-6427
- Riverside: (951) 358-5260
- Sacramento: (916) 875-6171
- San Bernardino: (909) 388-5751
- San Diego: (619) 542-4053

## Prior Authorization

Prior authorization or approval certification for either the OB or CPSP services provided for pregnant or postpartum members [defined as up to 60 days after delivery] is not required.

Members may see any qualified contracted Provider/Practitioner, including their PCP, an obstetrician/gynecologist, or a nurse midwife for prenatal care. Note: members in capitated IPA/Medical Groups must obtain an obstetrical Provider/Practitioner within their IPA/Medical Group network.

## Member Participation

Prior to the administration of any assessment, drug, procedure, or treatment, the member must be informed of the following:

- Potential risks or hazards which may adversely affect her or her unborn infant during pregnancy, labor, birth, or postpartum.
- Alternative therapies available to her.
- The member has a right to consent to or refuse the administration of any assessment, drug.
- Procedure, test, or treatment. The refusal of any MHC member to participate in CPSP must be documented in the member's medical record by the Provider/Practitioner or Perinatal Support Staff offering the CPSP service. Member participation is strongly encouraged but is voluntary.

Perinatal Support Staff as defined in this document includes:

- Certified Nurse Midwives
- Registered Nurse Practitioners (Family and/or Pediatric)
- Physician Assistants
- Registered Nurses
- Social Workers
- Psychologist
- Dietitians
- Health Educators
- Childbirth Educators
- Comprehensive Perinatal Health Workers (CPHW)
- Medical Groups
- Medical Clinics
- Hospitals
- Birthing Centers
- Case Manager

## Preventive Care

MHC requires contracted Providers/Practitioners of Perinatal Services to adhere at minimum to the current American College of Obstetrics and Gynecologists (ACOG) Standards, current edition.

MHC Prenatal Preventive Care Guidelines (PHGs) are derived from recommendations from nationally recognized organizations, such as the ACOG, U.S. Preventive Services Task Force, the American Academy of Family Physicians, and others. They are updated annually. The Prenatal PHG is available on the MHC webpage at: MolinaHealthcare.com.

## Perinatal Services Available to Members and Providers/Practitioners

The MHC UM Department shall be responsible for reviewing all referrals and treatment authorization requests for Perinatal Services of MHC members where prior authorization is required. Please refer to MHC's Prior Authorization Guide in the Healthcare Service Section.

## Frequency Scheduling of Perinatal Visits/Re-Assessments

MHC Providers/Practitioners shall follow ACOG's Guidelines for Perinatal Care regarding the frequency of visits/reassessments: Uncomplicated Pregnancy

- Every four weeks for the first 28 weeks
- Every two to three weeks until the 36th week
- After the 36th week, then weekly until delivery
- Postpartum, three to eight weeks after delivery

## Complicated/High-risk Pregnancy

- Frequency as determined by the member's Provider/Practitioner or Perinatal Support Staff according to the nature and severity of the pregnant member identified risk(s)
- Women with medical or obstetrical risks may require closer surveillance than the ACOG recommendations

## Biochemical Lab Studies

The Perinatal Support Staff shall ensure the following biochemical lab studies are completed as part of the member's initial risk assessment:

- Urinalysis, including microscopic examination and infection screen
- Hemoglobin/Hematocrit
- Complete Blood Count
- Blood Group, ABO and RH type
- Antibody screen
- Rubella antibody titer

- Syphilis screen (VDRL/RPR)
- Gonorrhea culture
- Chlamydia culture
- Urinary Ketones
- Serum Albumin
- Hepatitis B virus screen
- Cervical Cytology
- Tuberculosis testing
- Hemoglobin electrophoresis
- Blood volume
- One-hour glucose screen
- Screening for Genetic Disorders

The Perinatal Support Staff shall ensure all pregnant Members who have a history of one or more of the following shall have genetic disorder screening performed as part of the Member's initial risk assessment and are referred to a genetic counseling center or genetic specialist, as appropriate:

- Advanced maternal age (35 years of age or older)
- Previous offspring with chromosomal aberration
- Chromosomal abnormality in either parent
- Family history of a sex-linked condition
- Inborn errors of metabolism
- Neural tube defects
- Hemoglobinopathies
- Ancestry indicating risk for Tay-Sachs, Phenylketonia (PKU), Alpha or Beta Thalassemia, Sickle Cell Anemia, and Galactosemia

The Perinatal Support Staff must initiate appropriate interventions in response to any problems, needs, or risks identified during the initial combined risk assessment and document in the Member's Individualized Care Plan. Upon the Provider/Practitioner's recommendations and Member consent, the appropriate procedure(s) shall be performed (i.e., amniocentesis). The Provider/Practitioner shall give results of procedure(s) to the Member. Appropriate follow-up intervention shall occur, as necessary.

### Initial Combined Prenatal Risk Assessment/Reassessment/Reassessment of the Pregnant Member Overview

The Initial Combined Prenatal Risk Assessment/Re-Assessment is a combined risk assessment which includes medical/obstetrical, psychosocial, nutritional, and health educational components.

## Perinatal Support Staff Responsibilities

Perinatal Support Staff shall be responsible for assessing and evaluating the following:

- Member's Prenatal Assessment Profile
- Women's Food Frequency Questionnaire
- Prenatal Weight Gain Grid - Nutritional Assessment
- Psychosocial and Health Education assessment of the pregnant Member
- Individualized Care Plan, as appropriate, utilizing the following initial prenatal assessment tools.
- Perinatal Support Staff shall report all relevant information obtained during their assessments/reassessments to the Provider/Practitioner and document in the Member's record.
- Prenatal Assessment Profile shall be available in threshold language for the specific geographic areas of membership.
- Perinatal Support Staff shall be available to assist member in completion of Prenatal Assessment Profile if member is unable to complete independently.
- Perinatal Support Staff signature shall be required if assistance was provided to Member for completion of Prenatal Assessment Profile.
- Perinatal Support Staff shall review Member's response to the Prenatal Assessment Profile, identify, and discuss any responses that could indicate a potential risk.
- Perinatal Support Staff shall assign a risk status of "High, Medium, or Low" for each answer on the Prenatal Assessment Profile as determined by the Member's response.
- Perinatal Support Staff must initiate appropriate interventions in response to the Member's identified and assigned risk status from the Prenatal Assessment Profile.

## Nutritional Assessment/Reassessment – Women's Food Frequency Questionnaire

- Re-caps the Member's food intake for the prior 24 hours to determine pregnant Member's current nutritional status.
- Women's Food Frequency Questionnaire shall be available in threshold languages for the specific geographic areas of membership. Perinatal Support Staff shall be available to assist Member in completion of Women's Food Frequency Questionnaire if Member is unable to complete independently.
- Perinatal Support Staff shall review Member's response to the Women's Food Frequency Questionnaire and discuss any responses that could indicate a barrier to adequate nutritional intake (i.e. alcohol/tobacco or drug use; infant feeding problems; or socioeconomic factors potentially affecting dietary intake). Member will be evaluated for the WIC Program, Food Stamps, etc. Member must be referred to the WIC Program within four weeks of the first prenatal visit. The Perinatal Support Staff shall initiate appropriate interventions in response to the Member's identified nutritional risk status. The Perinatal Support Staff shall utilize relevant information obtained from the Women's Food Frequency Questionnaire to assist in the development of the member's Individualized Care Plan.

### Anthropometric Assessment – Prenatal Weight Gain Grid

- The Perinatal Support Staff shall obtain the Member's weight (in pounds) at the initial prenatal assessment and plot on the DHCS-approved Prenatal Weight Gain Grid
- The Perinatal Support Staff shall obtain a new weight at each perinatal assessment and plot accordingly on the Prenatal Weight Gain Grid. The Perinatal Support Staff shall compare the current weight and the total amount gained with the gain expected for the Member. The Perinatal Support Staff shall consider the results of weight assessment and results of the dietary and clinical assessments to determine appropriate nutritional interventions.
- The Perinatal Support Staff shall initiate appropriate interventions in response to the Member's identified risk status regarding weight.

### Psychosocial Assessment/Re-Assessment

The Perinatal Support Staff shall be responsible for the Psychosocial Assessment/Re-assessment which includes:

- Current living status
- Personal adjustment and acceptance of pregnancy (e.g. "Is this a wanted or unwanted pregnancy?")
- Substance use/abuse
- Member's goals for herself in this pregnancy
- Member's education, employment, and financial material resources
- Relevant information from the medical history, including physical, emotional, or mental disabilities
- Experience within the health care delivery system and/or any prior pregnancy

### Health Education Assessment/Re-Assessment

The Perinatal Support Staff shall be responsible for the Health Education Assessment/Re-Assessment which includes:

- Member and family/support person(s) available to Member
- Motivation to participate in health education plans
- Disabilities which may affect learning
- Member's expressed learning needs and identified learning needs related to diagnostic impressions, problems, and risk factors
- Primary languages spoken and written
- Education and current reading level
- Current health practices (i.e., Member's religious/cultural influences potentially affecting the Member's perinatal health)
- Evaluation of mobility and residency. Transportation assistance shall be considered when the resources immediately available to the maternal, fetal, or neonate Member are not adequate to deal with the actual or anticipated condition

- Evaluation for level of postpartum self-care, infant care to include immunizations and car seat safety

## Provider/Practitioner's Responsibilities

Provider/Practitioner shall be responsible for the completion of the medical/obstetrical assessment portion of the initial combined prenatal risk assessment of the pregnant Member and may utilize any of the following perinatal assessment forms:

- POPRAS
- Hollister
- ACOG

A copy of the Provider/Practitioner's completed perinatal assessment form, (POPRAS, Hollister or ACOG), must be forwarded to the hospital identified for Member's delivery by the Member's 35th week of gestation. Provider/Practitioner shall direct Members with identified risks to hospitals with advanced obstetrical and neonatal units. Provider/Practitioner's Medical/Obstetrical Assessment includes:

- History of previous cesarean sections
- Operations on the uterus or cervix
- History of premature onset of labor
- History of spontaneous or induced abortion
- Newborn size; small or large for gestational age
- Multiple gestation
- Neonatal morbidity
- Fetal or neonatal death
- Cardiovascular disease
- Urinary tract disorders
- Metabolic or endocrine disease
- Chronic pulmonary disease
- Neurological disorder
- Psychological illness
- Sexually transmitted diseases
- Identification of medication taken which may influence/affect health status
- HIV/AIDS Risk assessment/testing and counseling (Senate Bill 899) must be offered to all pregnant Members at initial prenatal assessment. Documentation in Member's medical record must include that assessment, testing, and counseling was offered
- Documentation must include if member "accepted" or "refused" risk assessment, testing, or counseling
- Blood Pressure

Provider/Practitioner must initiate appropriate interventions in response to any problems, needs, or risks identified during the initial combined risk assessment phase. This includes health education, nutrition, and psychosocial assessment, and document in the Member's Individualized Care Plan, accordingly.

Perinatal Support Staff Responsibilities Second (2nd) and Third (3rd) Trimester Re-assessments of the Pregnant Member:

- Perinatal Support Staff shall utilize the Combined second (2nd) and third (3rd) Trimester Re- Assessment Forms to ensure a continuous, comprehensive assessment of the Member's status in each trimester and shall update the Member's Individualized Care Plan, accordingly
- Anthropometric Assessment - Prenatal Weight Gain Grid
- Perinatal Support Staff shall obtain the Member's weight (in pounds) at each trimester
- Reassessment and plot on the Prenatal Weight Gain Grid
- Perinatal Support Staff shall compare the total amount gained since the prior assessment against the weight gain expected for the Member
- Perinatal Support Staff shall consider the results of weight assessment and dietary and clinical assessments to determine appropriate nutritional interventions

Provider/Practitioner's Responsibilities - Second (2nd) and Third (3rd) Trimester Reassessment of the Pregnant Member:

- During the second (2nd) and third (3rd) trimester re-assessment phase, the Provider/ Practitioner shall be responsible to update the POPRAS, Hollister, or ACOG form, to ensure the continuous, comprehensive assessment of the Member's medical/obstetrical health status
- The POPRAS, Hollister, or ACOG form was initiated by the Provider/Practitioner at the initial combined risk assessment phase and the same medical/obstetrical assessment form shall be utilized throughout the Member's second (2nd) and third (3rd) trimester reassessment phases
- The POPRAS, Hollister, or ACOG form shall be utilized to document the Provider/Practitioner's assessment and identify any problems/risks/needs that may have occurred or changed since the Provider/Practitioner completed the previous assessment; the information obtained by the Provider/Practitioner shall be utilized to update the Member's Individualized Care Plan, accordingly

Provider/Practitioner's medical/obstetrical assessment of the member's health status shall include, but not be limited to:

- Blood pressure, weight, uterine size, fetal heart rate, presence of any edema, and Leopold's maneuvers
- After quickening, the Provider/Practitioner shall inquire and instruct Member on completing fetal kick count after 28 weeks gestation
- Education and counseling on signs and symptoms of preterm labor and appropriate actions to take
- Provider/Practitioner must initiate appropriate interventions in response to any problems, needs, or risks identified during the Member's trimester re-assessment phase and document in the member's Individualized Care Plan, accordingly

## Combined Postpartum Assessment for the Member

Provider/Practitioner's Responsibilities Postpartum Phase:

- Provider/Practitioner's postpartum assessment must occur within 21 to 56 days post-delivery
- Postpartum assessment two weeks post C-section falls outside of this requirement
- Provider/Practitioner shall be responsible for assessing the Member's current medical/obstetrical health status by referencing the POPRAS, Hollister, or ACOG form which was initiated by the Provider/Practitioner at the initial prenatal risk assessment phase and updated with assessment information obtained during the second (2nd) and third (3rd) trimester re-assessment phases to ensure a continuous assessment of the postpartum Member. The POPRAS, Hollister, or ACOG form shall be utilized to document the Provider/Practitioner's assessment and identify any problems/risks/needs that may have occurred or changed since the previous Member assessment
- Information obtained by the Provider/Practitioner shall be utilized to update the Member's Individualized Care Plan accordingly
- Provider/Practitioner must initiate appropriate interventions in response to any problems/risks/needs identified during the Member's postpartum phase and document in the Member's Individualized Care Plan, accordingly

Perinatal Support Staff Responsibilities - Postpartum Phase [three to eight weeks after delivery]:

- Perinatal Support Staff shall utilize the Combined Postpartum Assessment Form to provide for a comprehensive assessment of the postpartum Member in the following areas and update the Member's Individualized Care Plan
- Anthropometric Assessment - Prenatal Weight Gain Grid. Perinatal Support Staff shall obtain the Member's postpartum weight (in pounds) and plot on the Prenatal Weight Gain Grid. Perinatal Support Staff shall consider the results of the weight, dietary, and clinical assessments to determine the appropriate nutritional interventions
- Nutritional Assessment - Women's Food Frequency Questionnaire. Member shall complete the Women's Food Frequency Questionnaire that re-caps the food intake for the prior 24 hours to determine nutritional status and any potential economic barriers to adequate nutrition for the Member and infant. Member to be evaluated for the WIC Program, Food Stamps, etc. Perinatal Support Staff shall counsel breast-feeding mothers on dietary needs of breast-feeding and management of specific breast-feeding problems, i.e., address Member's individual concerns and needs, refer high-risk Members for appropriate intervention

## Health Education Assessment

- Perinatal Support Staff shall evaluate the Member's level of health education regarding postpartum self-care and infant care and safety to include car seat, immunizations, breast-feeding, and well-childcare (CHDP). Perinatal Support Staff

shall identify those health education behaviors, which could promote risk to the postpartum Member or the infant
- Perinatal Support Staff shall discuss and counsel the postpartum Member on smoking cessation, substance and alcohol use, family planning and birth control methods, and provide information on Family Planning Centers, as appropriate
- Perinatal Support Staff shall identify goals to be achieved via health education interventions
- Perinatal Support Staff to discuss importance of referral of infant for CHDP exam, immunizations, and well- childcare
- Perinatal Support Staff shall educate the Member on how to enroll the newborn in the Plan and how to select a PCP for the newborn

### Psychosocial Assessment

- Perinatal Support Staff shall identify psychosocial behaviors which could promote a risk to the postpartum Member or the infant
- Perinatal Support Staff shall identify and support any strengths and habits oriented towards optimal psychosocial health
- Perinatal Support Staff shall identify goals to be achieved via psychosocial interventions
- Perinatal Support Staff must initiate appropriate interventions in response to any problems, needs, or risks identified in the member's postpartum phase and document in the Member's Individualized Care Plan, accordingly

### Complicated/High-risk Pregnancy - Identification and Interventions

- Early identification of complicated/high-risk pregnancy is critical to minimizing maternal and neonatal morbidity
- Both Providers/Practitioners and Perinatal Support Staff shall be responsible for identifying the complicated/high-risk pregnancy and providing the appropriate intervention(s)
- Referrals to physician specialists; i.e., Perinatal Specialist, Neonatal Specialist
- Coordinating with other appropriate medically necessary services
- Coordinating with appropriate support services/agencies
- Referrals to the Local Health Department support agencies
- Coordinating with MHC Perinatal Services Staff for appropriate interventions and follow-up
- Coordinating with MHC Medical Case Manager for appropriate interventions and follow-up through the Case Coordination/Management process of Perinatal Services

### Individualized Care Plans (ICPs)

- All pregnant Members, regardless of risk status, must have an ICP
- ICPs must be initiated at first prenatal visit

- ICPs must be reviewed and revised accordingly, each trimester at the minimum, throughout the pregnancy and postpartum phases, by the Provider/Practitioner and the Perinatal Support Staff members

ICPs must address/document the following four components:

- Nutritional Assessment
- Psychosocial Assessment
- Health Education Assessment
- Medical/Obstetrical Health Status Assessment

ICPs documentation within the four component areas must address the following:

- Nutritional Assessment: Prevention and/or resolution of nutritional problems. Support and maintenance of strengths and habits oriented toward optimal nutritional status and goals to be achieved via nutritional interventions
- Psychosocial Assessment: Prevention and/or resolution of psychosocial problems
- Support and maintenance of strengths in psychosocial functioning and goals to be achieved via psychosocial interventions
- Health Education Assessment: Health education strengths, prevention and/or resolution of health education problems and/or needs and medical conditions and health promotion/risk reduction behaviors, goals to be achieved via health education interventions and health education interventions based on identified needs, interests, and capabilities
- Medical/Obstetrical Health Status Assessment: Continuous evaluation of the Member's medical and obstetrical health status

ICPs must be developed from multidisciplinary information obtained and interventions initiated resulting from, but not limited to, the following:

- Prenatal Assessment profile;
- Women's Food Frequency Questionnaire;
- Prenatal Weight Gain Grid;
- Providers/Practitioners assessment to include Medical/Obstetrical Health status;
- Providers/Practitioners second (2nd) and third (3rd) Trimester re-assessment to include
- Medical/Obstetrical Health status; and,
- Perinatal Support Staff's individualized review of member and their Psychosocial, Health Education, and Nutritional Assessment results.

ICPs shall serve as an effective tool for the ongoing coordination and dissemination of information on the pregnant Member's perinatal care throughout all phases of the pregnancy and postpartum (i.e., initial visit, all trimester reassessments and postpartum). For any of the multidisciplinary Perinatal Support Staff or Provider/Practitioner involved with the Member, ICPs shall serve as an identification source/summary of prioritized problems, needs, or risk conditions as identified.

- ICPs must be created and individualized for each pregnant Member

- ICPs must be created in conjunction with the pregnant Member
- ICP must clearly define who is responsible for implementing the proposed interventions and the timeframes

## Pregnancy Rewards Program

The Pregnancy Rewards program encompasses Member outreach, and Member and provider education and awareness to facilitate the timely receipt of prenatal and postpartum care. Molina employees work to identify and implement appropriate assistance and interventions for participating Members. The main focus of the pregnancy program is to identify pregnant women to help motivate them to complete necessary preventive exams and screenings for improved health outcomes for themselves and their new baby.

Pregnancy Rewards does not replace or interfere with the Member's physician assessment and care nor does it deviate from the Motherhood Matters® program.

### Program Goals

The goals of the Pregnancy Rewards program include:

- Identify pregnant Members as early as possible in the course of their pregnancy
- Identify newly pregnant Members, or members newly accessing prenatal care
- Increase percentage of Members who receive prenatal care within the first trimester or 42 days of enrollment
- Increase percentage of Members who receive a postpartum visit 21 to 56 days after delivery
- Improve access to care for Members facing barriers.
- Monitor program effectiveness through the evaluation of outcomes and Member feedback.

### Eligibility Criteria

Pregnancy Rewards is a population-based pregnancy rewards program, which includes all pregnant females of any age. To participate in the program, the Member must be Medi-Cal eligible and enrolled with MHC, residing in San Bernardino, Riverside, Sacramento, San Diego or Imperial County.

### Referral Source

Potential participants may be identified from several sources including, but not limited to:

- Physician referral (Pregnancy Notification Report Form ("PNR" Form) Providers/Practitioners are required to notify MHC within seven days of a positive pregnancy test by completing the PNR from and faxing toll free to (855) 556-1424. If you have any questions or need assistance, please call (877) 665-4628
- State aid categories on monthly eligibility files when available

- Member self-referral
- Internal Molina Employee referral (i.e. Member Services, Health Education, Nurse Advice Line, Community Connectors, etc.)
- Utilization Management (as a result of authorization requests or triage service calls)
- Pharmacy utilization data
- Physician Referrals
- Claims data
- Lab data
- Data from Health Risk Assessments

### Program Components

1. Outreach to Members
    A. Pregnancy Notification/Identification – Molina identifies Members who are pregnant through a variety of resources
    B. Telephone outreach – Members are contacted via telephone by specially trained Molina staff using a standardized script and asked questions designed to identify if the Member is pregnant and if she needs assistance
    C. Additional resources – Information on health management-related programs that the Member can 'opt-in'
    D. All Members will receive assistance with scheduling provider appointments and overcoming barriers to access (e.g., transportation, language, etc.)
    E. The outreach may also incorporate home health visits to help Members who struggle to complete their appointments for various reasons
    F. All Members will receive a postpartum telephonic outreach to educate and assist with scheduling a postpartum visit, newborn follow-up visit and answer any questions
    G. The maternity team is available to assist Members with follow up questions related to all materials distributed and refer accordingly
    H. All Members will receive annual reminders for flu vaccination

## Maternity Program

Maternity Program encompasses clinical case management, Member outreach, and Member and Provider/Practitioner education to manage high risk pregnant Members. The Perinatal Case Management staff works closely with the Provider/Practitioner community in the identification, assessment, and implementation of appropriate intervention(s) for every Member participating in the program. The program comprises multi- departmental activities to ensure the coordination and delivery of comprehensive services to participating Members. The main focus of the program is on Member outreach to identify high risk pregnant women and the subsequent provision of risk assessment, education, and case management services.

Maternity program does not replace or interfere with the Member's physician assessment and care. The program supports and assists physicians in the delivery of

care to the Members. For Members who are receiving CPSP services at the time of entry into the Maternity Program will serve as back-up and additional support resource.

The goals of pregnancy management program are to:

- Improve MHC knowledge of newly pregnant Members, or members newly accessing prenatal care
- Identify all pregnant Members as early as possible in the course of their pregnancy
- Improve the rate of screening pregnant Members for potential risk factors by the administration of initial and subsequent assessments
- Provide education services to high-risk pregnant Members and their families
- Refer Members at high risk for poor pregnancy outcome to perinatal case management
- Provide coordinated, integrated, continuous care across a variety of settings
- Actively involve Providers/Practitioners, Members, families, and other care providers in the planning, provision, and evaluation of care for high-risk Members
- Meet patients', families', and Providers/Practitioners' expectations with pregnancy care
- Improve the quality of information collection and statistical analysis; in order to assess the effectiveness of the program and to project future needs
- Monitor program effectiveness through the evaluation of outcomes

## Eligibility Criteria for Program Participation and Referral Source

The Maternity Program is a population-based pregnancy program, which includes high risk pregnant females of any age. To participate in the program, the Member is Medi-Cal eligible and enrolled with MHC, resides in San Bernardino, Riverside, Sacramento, San Diego, or Imperial Counties and has been identified as a high-risk pregnant Member through screening.

## Referral Source

Potential participants may be identified from a number of sources including, but not limited to:

- Physician referral (Pregnancy Notification Report Form ("PNR" Form) Providers/Practitioners are required to notify MHC within seven (7) days of a positive pregnancy test by completing the PNR from and faxing toll free to (855) 556-1424. If you have any questions or need assistance, please call (877) 665-4628.
- Members' self-referral.
- Member Services (as a result of member outreach calls).
- Utilization Management (as a result of authorization requests or triage service calls).
- Quality Improvement (as a result of various reports submitted monthly by IPAs/Medical Groups).
- Pharmacy utilization data
- Nurse Advice Line referrals
- Laboratory Data

## Program Components

### 1. Assessment and Referral

Following an initial health assessment performed by the Maternity Program Coordinator, the risk factors are scored and based on the assessment outcome pregnant members are risk-stratified into two levels:

I. Normal pregnancy - No identified risks
II. High risk pregnancy - Risk factors identified

Perinatal Case Management staff reviews all level II members for actual or potential at risk pregnancy. High- risk indicators include, but are not limited to:

- Age under 18 or over 35
- Unstable or high-risk social situation (inadequate shelter or nutrition; abuse)
- Current or past gestational diabetes or other medical co-morbidity
- History of preterm labor or premature birth
- History of fetal demise, stillbirth, or other poor pregnancy outcome
- Smoking, alcohol, drug, or other substance abuse
- History of behavioral health problems

Members who are positive for any of the above indicators, or have other indications as determined, are enrolled in the Maternity program and remains in prenatal case management for detailed assessment and further evaluation and intervention(s), as appropriate. Following the completion of initial assessment, regular follow up assessments are conducted throughout the pregnancy. A postpartum depression is completed one to five weeks after the delivery.

### 2. Health Education

For those participants with identified risks that can be addressed through educational intervention, additional Member education services may be provided by a health educator and/or social worker within the Care Management team. Participants identified with nutritional risk, may also include a comprehensive nutrition assessment and the development of a meal plan by a Registered Dietitian.

### 3. High-risk Case Management

The case management of high-risk pregnancy incorporates an intensive process of case assessment, planning, implementation, coordination, and evaluation of services required to facilitate an individual with high-risk obstetrical conditions through the health care continuum. The program consists of a comprehensive approach toward evaluating the Member's overall care plan through an assessment and treatment planning process. The case management process comprises case triage and collaboration with treating physician(s), ancillary and other Providers/Practitioners, and development of an individual care plan.

Perinatal case management registered nurses, in conjunction with the treating physician, coordinate all health care services. This includes the facilitation of appropriate specialty care referrals, coordination of home health and DME service, and referral to support groups/social services within the Member's community. MHC's case managers work closely with Public Health Programs to ensure timely and appropriate utilization of available services (e.g., WIC) and may include California Children's Services for Members under age 21. Additionally, case managers coordinate services with the Comprehensive Perinatal Services Program in cases where the Member is already receiving such services.

To ensure timely follow-up with the Provider/Practitioner, the database supporting the program has the capability to generate reminders for call backs for trimester specific assessments, prenatal visits, postpartum visits, and well-baby checkups.

**4. Provider Education**

To ensure consistency in the approach of treating high-risk pregnancy, MHC has developed clinical guidelines and pathways, with significant input from practicing obstetricians. While the guidelines originate from nationally recognized sources, their purpose is to serve as a starting point for Providers/Practitioners participating in health management systems program. They are meant to be adapted to meet the needs of Members with high-risk pregnancies, and to be further refined for individual patients, as appropriate. The guidelines are distributed to MHC network participating obstetrical Providers/Practitioners. Other methods of distribution and updating are via Just the Fax weekly electronic publications, continuing medical education programs, quarterly physician newsletter, and individual Provider/Practitioner contact.

## New Member Outreach

Information introducing the Maternity Perinatal Services Program, that emphasizes early entry into the program, is included in MHC's Welcome Package.

- The Welcome Package shall be mailed to all new MHC members or responsible party within seven days of enrollment
- Annually updated Evidence of Coverage shall be mailed to all MHC members or responsible party.
- The Welcome Package shall be printed and distributed in appropriate threshold languages for MHC members

## Focused Reviews/Studies

All compliance monitoring and oversight activities are undertaken with the goal of assisting and enabling the perinatal Provider/Practitioner to provide care and services that meet or exceed community/professional standards, Department of Health Care Services (DHCS) contractual requirements, and National Committee for Quality

Assurance (NCQA) standards and that health care delivery is continuously and measurably improved in both the inpatient and outpatient/ambulatory care setting.

Obstetricians with five or more deliveries require a Prenatal/OB medical record review once every three years. The performance goal is 85 percent or above for the following categories: Format and documentation; OB/CPSOP Guidelines (Perinatal Preventive Criteria); and Continuity and Coordination of Care. Audit results are reported to the Quality Improvement Committee.

### Grievances and Survey

- The QI Department utilizes Provider/Practitioner and member surveys to assess compliance with Plan standards
- The QI Department investigates, monitors, and provides follow-up to Provider/Practitioner and member grievances involving potential clinical quality issues

Findings are reported to the individual Provider/Practitioner, the Clinical Quality Improvement Committee, the Quality Improvement Committee, and/or the Professional Review (Credentials) Committee as appropriate.

## Nurse Midwife Services

Defined by Title 22, nurse midwife services are permitted under State law and are covered when provided by a Certified Nurse Midwife (CNM). MHC will provide access to and reimbursement for CNM services under State law. Federal guidelines have been established and Members have the right to access CNM services on a self-referral basis.

### Covered Services

All eligible MHC Members are eligible to receive the following limited care and services from a CNM:

- Mothers and newborns through the maternity cycle of pregnancy
- Labor
- Birth
- Immediate postpartum period, not to exceed six weeks

The CNM services must be provided within seven calendar days of request, based on the severity of the Member's condition.

### Procedure

Referral to a contracted CNM may be made by either a Primary Care Practitioner (PCP) or by the member requesting the services.

- Minors may access a CNM in accordance with MHC Policy and Procedure, Confidential Access to Service for Minors, or applicable policy
- The CNM will work under the supervision of a physician, as defined by law

### Notification

Members are notified of the availability of CNM services through their PCP or OB/GYN Providers/Practitioners. Members are also notified of availability of services through the Evidence of Coverage, which is distributed at the time of enrollment and annually thereafter.

### Supervising Providers/Practitioners

Supervising Providers/Practitioners will submit claims directly to MHC, in accordance with MHC's Claim Payment Policy and Procedures. This instruction also addresses the appeal process for denial of claims (Please reference to Claims Manual).

The CNM will be credentialed through the credentialing and re-credentialing process of allied health Providers/Practitioners at MHC or subcontracted affiliated plan.

## Special Supplemental Nutrition Program for Women, Infants & Children

The Women, Infants & Children (WIC) Supplemental Food Program is a local county program that is available for eligible pregnant women, infants and children under 5. This program provides an evaluation and, if appropriate, a referral for pregnant, breast-feeding, or postpartum women or parents or guardians of a child under five years of age for services. Program services include nutrition assessment and education, referral to health care, and monthly vouchers to purchase specific food needed to promote good health for low-income pregnant, breast-feeding, and postpartum women, infants, and children under five years of age with a medical/nutritional need.

### Program Services

WIC participants receive a packet of food vouchers each month, which they can redeem at the local retail market of their choice, for supplemental food such as milk, eggs, cheese, cereal, and juice. WIC participants attend monthly nutrition and health education classes and receive individual nutrition counseling from registered dieticians and nutrition program assistance. WIC also refers participants to other health and social service programs. Federal law requires the WIC program to promote and support breast-feeding.

### Policy

As part of the initial evaluation, Provider/Practitioners will document the referral of pregnant, breast-feeding, or postpartum women or a parent/guardian of a child under age five to the WIC program. Evidence of the referral will be documented in the

Member's medical record. Children will be screened for nutritional problems at each initial, routine, and periodic examination. Children and women, who are pregnant, postpartum, and breast-feeding, will be referred to the local WIC supplemental-food program. Follow-up of WIC referrals will be completed and documented at each subsequent periodic visit.

### Identifying Eligible Members

Members are eligible for WIC services if they meet one of the following criteria:

- Pregnant woman
- Breast-feeding woman (up to one year after childbirth)
- Postpartum woman up to six months after childbirth)
- Child under age five years who is determined to be at nutritional risk by a health professional

To maintain eligibility, members must also:

- Receive regular medical checkups
- Meet income guidelines
- Reside in a local agency service area

### Referrals to WIC

PCPs are responsible for referring eligible Members to WIC programs, providing required documentation with each referral, and coordinating follow-up care. Upon request of the PCP, MHC will assist in the coordination of the WIC referral, including assistance with appointment scheduling in urgent situations.

Referrals to WIC services must be made on one of the following forms:

- PM-160, CHDP Form
- PM-247, WIC Pediatric Referral Form
- PM-247A, WIC Referral for Pregnant Women Form
- Nutritional Questionnaire
- Provider/Practitioner Prescription Pad

Federal WIC regulations require hemoglobin or hematocrit test values at initial enrollment and when participants are re-certified. These biochemical values are used to assess eligibility for WIC program benefits. Children will be referred to WIC for the following conditions:

- Anemia - Please refer to the Pediatric and Child Health Services Section of this Manual for details
- Abnormal growth (underweight, overweight)
- Underweight is defined as being in the fifth percentile of the Pediatric Standard Growth Chart as established by the American Academy of Pediatrics
- Overweight is defined as being over the 120th percentile of the Pediatric Standard Growth Chart as established by the American Academy of Pediatrics

Women who are pregnant, postpartum, and/or breast-feeding will be referred to WIC according to the MHC perinatal protocols located in the Women's and Adult Health Services Including Preventive Care Section of this Manual.

Blood tests will be conducted not more than 60 days prior to WIC certification and be pertinent to the category for enrollment. The following data will be collected:

- Data for persons certified as pregnant women will be collected during their pregnancy
- Data for postpartum and breast-feeding women will be collected after the termination of pregnancy

The biochemical values that are required at each certification include: WOMEN - PERINATAL, POSTPARTUM, BREAST-FEEDING:

- Hemoglobin or hematocrit values are required at each certification including:
  - Initial prenatal enrollment
  - Postpartum certification - up to six weeks after delivery
  - Certification of breast-feeding women - approximately six months after delivery
- Hemoglobin or hematocrit values are required at initial enrollment and with each subsequent certification approximately every six months. Biochemical data is not required when:
  - An infant is six months of age or under at the time of certification
  - A child over one year had blood values within normal limits at the previous certification. In this case, the hemoglobin and hematocrit (H&H) is required every 12 months

## Assessments

All WIC eligible Members will have a nutritional assessment completed at the time of the initial visit by the PCP. Children will be screened using the following tools to assess nutritional status:

- Nutritional assessment history form
- Physical examination of height/weight
- Laboratory screening of hemoglobin or hematocrit
- Laboratory screening of blood lead levels

Nutritional education will be done by the PCP and documented in the Member's medical record. The MHC Provider Services Department will inform Providers/Practitioners of the Federal WIC anthropometric and biochemical requirements for program eligibility, enrollment, and certification.

Providers/Practitioners will complete the WIC Medical Justification Form for Members requiring non-contract special formula and state the diagnosis and expected duration of the request for the special formula.

Provider/Practitioners will provide a copy of the Member's health assessment, including nutritional risk assessment, to the local WIC office after the Member's consent has been received to release this information.

### Medical Documentation

It is essential that Providers/Practitioners document WIC referrals in the Member's medical records. The documentation can be a copy of the referral form and/or notes in the Member's file documenting the visit and subsequent referrals. WIC considers findings and recommendations of referrals to be confidential and declines to share information regarding individual referral findings. WIC has agreed to share aggregate data pending clarification regarding confidentiality from the Department of Agriculture. Until clarification is made, the PCP should encourage Members to inform him/her of the outcome of their WIC visit, thereby allowing the PCP to provide appropriate and consistent follow-up, noting outcomes in the progress notes of the Member's medical record.

### Local Health Department Coordination

The WIC offices, through the Local Health Department, will function as a resource to MHC and Providers/Practitioners regarding WIC policies and guidelines, program locations, and hours of operation.

## Breast-feeding Promotion, Education, and Counseling Services

Primary Care Providers/Practitioners, Pediatric Providers/Practitioners, and Ob-Gyn Providers/Practitioners must provide postnatal support to postpartum breast-feeding mothers through continued health education, counseling, and the provision of medically necessary interventions such as lactation durable medical equipment.

Postpartum women should receive the necessary breast-feeding counseling and support immediately after delivery. Assessment of breast-feeding support needs should be part of the first newborn visit after delivery.

MHC endorses the statement by the American Academy of Pediatrics, that, "breast-feeding ensures the best possible health as well as the best developmental and psychosocial outcomes for the infant" (AAP Policy Statement, 2005). The numerous benefits of breast-feeding for the infant, mother and the community have been well researched and documented. They include nutritional, developmental, immunological, psychosocial, economic and environmental benefits. It is recognized that there may be some barriers to breast-feeding due to physical or medical problems with the mother or infant, poor breast-feeding technique, or complementary feeding. All postpartum women should be offered breast-feeding resources to help them make informed choices about how to feed their babies and to get the information and support they need to breastfeed successfully. The distribution of promotional materials containing formula company logos is prohibited as per state MMCD policy letter 98-10.

All pregnant Members should be referred to the Pregnancy Rewards program for information or incentives related to prenatal and postpartum services. High risk pregnant Members should be referred to the Maternity Program. The Maternity Program staff conduct postpartum assessments and health education to Members referred to the Maternity Program. Breast-feeding promotion and counseling are included in third trimester assessment and the postpartum health assessment conducted as part of the program. Members can also be referred to lactation counselors through local WIC offices. For breast-feeding education materials to support breast-feeding Members, please contact the Health Education Department at (866) 472-9483.

### Durable Medical Equipment

Lactation management aids, classified as Durable Medical Equipment (DME), are covered benefits for MHC Members. Specialized equipment, such as electric breast pumps, will be provided to breast-feeding MHC Members when medically necessary.

### Human Milk Bank

Medi-Cal benefits include enteral nutritional supplemental or replacement formulas when medically diagnosed conditions preclude the full use of regular food. The provision of human milk for newborns will be arranged in the following situations:

- Mother is unable to breastfeed due to medical reasons and the infant cannot tolerate or has medical contraindications to the use of any formula, including elemental formulas

For information regarding human milk banks, please contact your local WIC office.

## Adult Preventive Care Services Guidelines

MHC implements programs to encourage preventive health behaviors which can ultimately improve quality outcomes. Preventive Health Guidelines (PHG) are updated annually and derived from recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians, and others. The recommended services noted in the Preventive Health and Clinical Practice Guidelines are based on clinical evidence; however, Providers/Practitioners and members should check with the Plan to determine if a particular service is a covered benefit.

- Preventive Health Guidelines: see website (www.MolinaHealthcare.com) for current and updated guidelines
- Clinical Practice Guidelines: see website (www.MolinaHealthcare.com) for current and updated guidelines

To request a hardcopy of the guideline, contact MHC's Provider Services at (855) 322-4075.

## Initial Health Assessments (IHA)

The Primary Care Physician (PCP) has the principal role to maintain and manage his/her assigned Members. The PCP conducts the Initial Health Assessment and provides necessary care to assigned Members and coordinates referrals to specialists and health delivery organizations as needed. The IHA is a comprehensive assessment that is completed during the Member's initial encounter with a selected or assigned PCP and must be documented in the Member's medical record. The IHA enables the Member's PCP to assess and manage the acute, chronic and preventive health needs of the Member.

The Department of Health Care Services recently updated the Staying Healthy Assessment (SHA)/Individual Health Education Behavioral Assessment (IHEBA) assessment tools. All assessment questions were updated in accordance with the guidelines of the US Preventive Services Task Force and other relevant governmental and professional associations. The DHCS and MHC require providers to administer an IHEBA to all Medi-Cal managed care patients as part of their IHA and well care visits. Members are required to have an IHA within 120 days of enrollment with the plan.

The goals of the SHA are to assist providers with:

- Identifying and tracking high-risk behaviors of Members.
- Prioritizing each Member's need for health education related to lifestyle, behavior, environment, and cultural and linguistic needs.
- Initiating discussion and counseling regarding high-risk behaviors.
- Providing tailored health education counseling, interventions, referral, and follow-up.

### IHA Overview & PCP Responsibilities

- All Members must have a complete IHA within 120 calendar days of enrollment
- This assessment should be done on the Member's initial visit, will be both gender and age specific, and include a history and physical examination.
- The IHA for Members under age 21 will be based on American Academy of Pediatrics (AAP) guidelines and will include the recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP). These preventive visits must include age specific assessments and services required by the Child Health and Disability Prevention Program (CHDP)
- The IHA for Members over age 21 will meet the guidelines addressed in U.S. Preventive Services Task Force (USPSTF) and recommendations delineated in MHC's Preventive Health and Clinical Practice Guidelines
- The IHA must be accompanied by an age-appropriate initial health education behavioral assessment, utilizing the MMCD developed "Staying Healthy" Assessment (SHA) tool
- PCPs are responsible for reviewing each Member's SHA in combination with the following relevant information: Medical history, conditions, problems, medical/testing results, and member concerns; Social history, including Member's demographic

data, personal circumstances, family composition, Member resources, and social support; and Local demographic and epidemiologic factors that influence risk status

- The PCP must review the assessment, provide needed counseling or other intervention, document on the assessment, and file in the Member's medical record with other continuity of care forms. The age- appropriate questionnaire must be reviewed with the Member and/or parent at least annually. Multi-lingual and age-appropriate Staying Healthy assessment forms are available on the MHC website and on the DHCS website. Please refer to the below link to access this information: http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx
- The SHA is an age-appropriate questionnaire that must be administered during the Member's IHA (within 120 days of the effective date of enrollment) and again at defined age intervals. Current Members who have not completed an updated SHA must complete it during the next preventive care office visit (e.g. well-baby, well-child, well-woman exam), according to the SHA periodicity table below
- It is recommended that page two of the completed "Staying Healthy" Assessments for age 12 - 17 should be placed under the "sensitive tab" in the medical record, preventing photocopying should a parent/guardian request the record. This precaution protects the confidentiality of the minor's disclosures, according to the MMCD letter 99-07, Individual Health Behavioral Assessment

The SHA Periodicity Table and SHA administration policy is summarized in the below table:

| Periodicity | Initial SHA Administration | Subsequent SHA Administration/Re-Administration | | SHA Review |
|---|---|---|---|---|
| Age Groups | Within 120 Days of Enrollment | 1st Scheduled Exam *(After entering new age group)* | Every 3-5 years | Annually *(Intervening years between administration of new assessment)* |
| 0-6 mo. | ✓ | | | |
| 7-12 mo. | ✓ | ✓ | | |
| 1-2 yrs. | ✓ | ✓ | | ✓ |
| 3-4 yrs. | ✓ | ✓ | | ✓ |
| 5-8 yrs. | ✓ | ✓ | | ✓ |
| 9-11 yrs. | ✓ | ✓ | | ✓ |
| 12-17 yrs. | ✓ | ✓ | | ✓ |
| Adult | ✓ | | ✓ | ✓ |
| Senior | ✓ | | ✓ | ✓ |

- Members must be informed that they may refuse to respond to any question or refuse to complete the entire IHA. Refusal must be documented in the Member's medical record. This may be done by noting on the assessment itself, signing, dating, and filing it in the medical record. When a Member refuses the IHA, the PCP must inform the Member of the benefits, risks, and suggest alternatives. The PCP must document such discussion and advice in the Member's medical record

- The results of the IHA must be documented by PCP in the Progress Notes section of the Member's medical record. The PCP may utilize an initial history and physical form that is specific to his/her practice. In the event that specific forms do not address all recommended areas, those findings are to be addressed in the Progress Notes section of the Member's medical record
- Perinatal Care Providers who care for MHC members during pregnancy may provide the IHA through initial perinatal visit(s), and must document that the prenatal visit(s) met IHA content and timeline requirements
- MHC will provide you with resources to assist you with implementation of IHA. Contact your MHC Provider Services Representative or MHC's Health Education Department at (855) 322-4075 with your request on "Staying Healthy" Assessment assistance
- MHC contacts Members within 30 calendar days of enrollment to encourage scheduling an appointment for an initial health assessment. Members are informed of the benefit in the Evidence of Coverage. The requirement is waived if the Member's PCP determines the Member's medical record contains complete and current information consistent with the IHA requirements (such as history and physical exam that is age and gender specific, evaluates risk factors, and the socioeconomic environment of a Plan Member)

### Initial Health Assessment Components

IHA consist of the following:

A. Comprehensive History: must be sufficiently comprehensive to assess and diagnose acute and chronic conditions which includes, but is not limited to the following:

1. History of Present Illness
2. Past Medical History
    a. Prior major illnesses and injuries
    b. Prior operations
    c. Prior hospitalizations
    d. Current medications
    e. Allergies
    f. Age-appropriate immunization status
    g. Age-appropriate feeding and dietary status
3. Social History
    a. Marital status and living arrangements
    b. Current employment
    c. Occupational history
    d. Use of alcohol, drugs, and tobacco
    e. Level of education
    f. Sexual history
    g. Any other relevant social factors
4. Review of Organ Systems

B. Preventive Services

1. Adults: referenced under IHA Overview
2. Members under 21 Years of Age: referenced under IHA Overview
3. Perinatal Services
    a. Must provide perinatal services for pregnant members according to the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG).
    b. The assessment must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit.
    c. Risks identified must be followed up with appropriate interventions and documented in the medical record.

C. Comprehensive Physical and Mental Status Exam

D. Diagnoses and Plan of Care

E. Individual Health Education Behavioral Assessment (IHEBA): the age specific and age-appropriate behavior risk assessment should address the following areas:

1. Diet and Weight Issues
2. Dental Care
3. Domestic Violence
4. Drugs and Alcohol
5. Exercise and Sun Exposure
6. Medical Care from Other Sources
7. Mental Health
8. Pregnancy
9. Birth Control
10. STIs/STDs
11. Sexuality
12. Safety Prevention
13. Tobacco Use and Exposure

## Dental Screening

MHC Members are entitled to an annual dental screening described in the periodic health exam schedules. Dental services, other than dental screenings, are not covered by MHC. They are carved out to Denti-Cal.

A dental screening will be performed at the time of all health assessments by the Primary Care Practitioner (PCP). The screening will include, but not necessarily be limited to:

- A brief dental history
- Examination of the teeth
- Examination of the gum
- Dental education

Findings of the dental screen, including education provided to the Member or family, will be documented in the Member's medical record.

### Primary Care Practitioner's (PCP) Responsibility

The PCP caring for pediatric Members should conduct a dental assessment to check for normal growth and development and for the absence of tooth and gum disease at the time of the initial health assessment and at each CHDP/EPSDT examination visit, according to the periodic health examination schedules. PCPs should perform a screening dental exam on adult Members and encourage their adult patients to receive an annual dental exam.

The PCP should perform an initial dental exam referral to a Medi-Cal approved dentist with the eruption of the child's first tooth or at 12 months of age, whichever occurs first, and continue to refer the Member annually thereafter. All referrals, and the reason for the referral, should be documented. Contractor shall provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental providers are not covered under this Contract in the member's medical record. Please refer the Member to a Denti-Cal provider for other needed dental services (see below).

### Referral Process

A dental referral does not require prior authorization. Each PCP office is encouraged to maintain a list of local fee-for-service Medi-Cal dentists to whom Members may be referred. Members may obtain the dental referral assistance from MHC's Customer Services Department. The Denti-Cal Beneficiary line is (800) 322-6384. Members can also be referred to the Denti-Cal website (Medi-Cal Dental Program - Members - Medi-Cal Dental - Find-A-Dentist).

## Vision Care Services

MHC's Members must be provided with access to covered vision care services.

### Referral

Members may be referred for vision care services by their PCP or may access vision care services on a self- referral basis. A referral for a diabetic retinal exam is not required if there is a diagnosis of diabetes. Members may obtain, as a covered benefit, one pair of prescription glasses every two years. No prior authorization is required for receipt of this benefit through a qualified participating Provider/Practitioner. Basic Member benefits include an eye examination with refractive services and prescription eyewear every two years.

Additional services and lenses are provided based on medical necessity for examinations and new prescriptions. Children have an enhanced benefit through EPSDT services (see the EPSDT section in this manual).

Contracted Providers/Practitioners will order the fabrication of optical lenses from the Prison Authority Optical Laboratories for Members enrolled in the health plan.

MHC Providers/Practitioners are to refer Members to March Vision Care for optometry vision care services at: (844) 336- 2724.

Note: if eye disease is suspected, the Member should be referred to an ophthalmologist.

### Routine Eye Examination

The PCP plays a vital role in detecting ocular abnormalities that require referrals for a comprehensive eye examination.

All children should undergo an evaluation to detect eye and vision abnormalities during the first few months of life and again at approximately three years of age. Children between four and six years of age should have a comprehensive eye examination in addition to the screening performed by the PCP. Children with prescription eyewear or contact lenses should have an eye examination annually.

Children should have a comprehensive eye examination by an ophthalmologist if they have one or more of the following indications:

- Abnormalities on the screening evaluation
- Recurrent or continuous signs or symptoms of eye problems
- Multiple health problems, systemic disease, or use of medications that are known to be associated with eye disease and vision abnormality
- A family history of conditions that cause, or are associated with, eye or vision problems
- Health and developmental problems that make screening difficult or inaccurate

## Family Planning Services

Members are allowed freedom of choice in selecting and receiving family-planning services from qualified Providers/Practitioners. Members may access family-planning services from any qualified family-planning Provider/Practitioner without referral or prior authorization. Members may access family-planning services from any qualified Provider/Practitioner, including their PCP, contracted or non-contracted Provider/Practitioner, OB/GYN Providers/Practitioners, nurse midwives, nurse practitioners, nurse physician assistants, Federally Qualified Health Centers (FQHC), and local county family-planning Providers/Practitioners.

The right of Members to choose a Provider/Practitioner for family-planning services will not be restricted. Members will be given sufficient information to allow them to make an

informed choice, including an explanation of what family-planning services are available to them.

Access to family-planning services must be convenient and easily comprehensible to Members. Members are to be educated regarding the positive impact of coordinated care on their health outcome, so they will be more likely to access services with MHC. If the Member decides to see an out-of-plan Provider/Practitioner, the Member should be encouraged to agree to the exchange of medical information between Providers/Practitioners for better coordination of care. The following family-planning services are available to all Members of childbearing age to prevent or delay pregnancy temporarily or permanently:

- Health education and counseling necessary to understand and to make informed choices about contraceptive methods
- Limited history and physical examination
- Medically indicated laboratory tests (except Pap smear provided by a non-contracted Provider/Practitioner where the plan has previously covered a Pap smear by a plan Provider/Practitioner within the last year).
- Diagnosis and treatment of sexually transmitted diseases
- Screening, testing, and counseling of at-risk individuals for HIV treatment
- Follow-up care for complications associated with contraceptive methods issued by the family -planning Provider/Practitioner
- Provision of contraceptive pills, devices, and supplies (including Norplant).
- Tubal Ligation
- Vasectomies
- Pregnancy testing and counseling.

The following are NOT reimbursable as family-planning services:

- Routine infertility studies or procedures
- Reversal of voluntary sterilization
- Hysterectomy for sterilization purposes only
- All abortions, including but not limited to, therapeutic abortions, spontaneous, missed, or septic abortions and related services (Note: Pregnancy testing and counseling performed by an out-of-plan family-planning Provider/Practitioner is reimbursable regardless of the member's decision to abort)
- Parking and childcare

## Provider/Practitioner Responsibilities

Providers/Practitioners may not restrict a Member's access to family-planning services, nor should a Provider/Practitioner subject a Member to any prior authorization process for family-planning services. Providers/Practitioners found to be non-compliant may be subject to administrative review and/or possible disciplinary action.

The family-planning Provider/Practitioner must obtain informed consent for all contraceptive methods, including sterilization

## Procedure

- Family-planning and Sexually Transmitted Disease (STD) services will be provided in a timely manner
- Members who request an office visit for STD or family-planning services is considered as an urgent care appointment request, requiring an appointment within 24 hours
- Family-planning services will be available through the PCP's office or through a referral from the PCP to a contracted specialist qualified to provide services, or to an out-of-network family-planning Provider/Practitioner
- For services to be rendered by contracted Providers/Practitioners within the MHC network, the PCP may initiate a referral on the same day as the Member presents. This referral does not require prior authorization from MHC's Utilization Management department
- For family-planning services requiring an inpatient stay, the PCP is to notify MHC's Utilization Management Department to coordinate care
- Should a Member request from the PCP a referral to a family-planning or STD Provider/Practitioner outside of MHC's contracted network, the PCP will educate the Member regarding the positive impact of coordinated care on his/her health outcomes, helping the Member to recognize the advantages of seeking services within MHC's network. If the Member still wants to see an out-of-plan Provider/Practitioner, the member should be encouraged to agree to the exchange of medical information between

## Providers/Practitioners for Coordination of Care

- The PCP should not refer Members to non-contracted Providers/Practitioners for family-planning, STD, or HIV services; however, the Member will be advised of his/her right of choice to family-planning Providers/Practitioners through the Evidence of Coverage
- When a Member presents, the PCP will evaluate the request for family-planning services and inform the Member of his/her recommendations and options

## Patient Information

Members will receive information to allow them to make an informed choice including:

- Types of family-planning services available
- Right to access these services in a timely and confidential manner
- Freedom to choose a qualified family-planning Provider/Practitioner

## Minors

Minors have the right to seek treatment in a confidential manner. (Refer to MHC policies, Confidential Access to Services for Minors, Collection, Use, Confidentiality, and Release of Primary Health Care Information).

## Documentation

The PCP will document recommendations made and options available, the consultation and counseling provided, and the response of the Member. The documentation will include any referral or recommendations.

Documentation by the Provider/Practitioner will be in compliance with MHC Policy, Medical Records Content and Documentation.

## Confidentiality

- The Member must give his/her consent to any Family-planning Services assessment and treatment. A signed, informed consent will be obtained when indicated by surgical or invasive procedure
- Records are to be maintained in a confidential manner according to MHC policy, Collection, Use, Confidentiality, and Release of Primary Health Care Information
- All information and the results of the Family-Planning Services of each Member will be confidential and will not be released without the informed consent of the Member
- Appropriate governmental agencies will have access to records without consent of the Member; i.e., Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Department of Health and Human Services (DHHS), Department of Justice (DOJ)

## Non-Compliance

Missed Family-Planning Service appointments within the MHC network will be addressed by utilizing MHC's policy for Failed or Missed Appointments.

Non-compliance by a M ember will be acted upon by the PCP through MHC policy, Access to Health Care, which addresses follow-up and documentation of failed or missed appointments.

## Coordination with Out-of-Plan Providers/Practitioners

Reimbursement to out-of-plan Providers/Practitioners will be provided at the applicable Medi-Cal rate appropriate to the Provider/Practitioner type, as specified in Title 22, Section 51501. Records obtained from out-of-plan Providers/Practitioners will be shared with the PCP for the purposes of assuring continuity of care. Out-of-plan Providers/Practitioners will be reimbursed for family-planning services only if:

- The out-of-plan Provider/Practitioner is qualified to provide family-planning services based on the licensed scope of practices
- The out-of-plan Provider/Practitioner must provide pertinent medical records sufficient to allow MHC to meet case management responsibilities
- MHC will reimburse contracted Providers/Practitioners at contracted rates

MHC will reimburse non-contract, out-of-plan Providers/Practitioners at the Medi-Cal fee-for-service rate. Reimbursement for family-planning services will only be made if the

Provider/Practitioner submits treatment records or documentation of the Member's refusal to release medical records to MHC along with billing information.

### Policies and Procedures

PCPs or their staff may obtain detailed information on any MHC policy/procedure by contacting the Provider Services Department at (888) 665-4621. Available policies include, but are not limited to:

- Confidential Access to Services to Minors
- Access to Health Care
- Collection, Use, Confidentiality, and Release of Primary Health Care Information
- Safeguarding and Protecting Medical Records

## Sexually Transmitted Diseases (STD)

MHC Members may access care for STDs without prior authorization requirements as stated in its contracts with the California Department of Health Care Services. In accordance with Federal Law, Medi-Cal Members are allowed freedom of choice of Providers/Practitioners when seeking STD services, without prior authorization. STD services include education, prevention, screening, counseling, diagnosis, and treatment.

### Participating Provider/Practitioner Responsibilities

Participating Primary Care Practitioners (PCPs) are responsible for the primary medical care of STDs. The PCP may perform services or refer Members to Local Health Department clinics, participating specialists, or upon request of the Member, to out-of-plan Providers/Practitioners. Each PCP is responsible to report certain information regarding the identification of STDs to the Local Health Department within seven days of identification.

When reporting to the Local Health Department, the following information must be included:

- Patient demographics: name, age, address, home telephone number, date of birth, gender, ethnicity, and marital status
- Locating information: employer, work address, and telephone number
- Disease information: disease diagnosed, date of onset, symptoms, laboratory results, and medications prescribed

The PCP will provide and document preventive care and health education, counseling, and services at the time of any routine exam for all Members with high-risk behaviors for STDs. Access to confidential STD services by minors is a benefit of MHC.

## Minors

Members aged 12 and over may access STD services without parental consent. MHC Policy, Confidential Access to Services for Minors, may be obtained by contacting the Provider/ Practitioner Quality Improvement Department.

## Non-Participating Provider/Practitioners

MHC requests that non-participating Providers/Practitioners contact the Customer Services Department at MHC to confirm eligibility and benefits and to obtain billing instructions for MHC Members. Non-participating Providers/Practitioners are requested to contact the affiliated health plan's Member Services Department to confirm eligibility and benefits and to obtain billing instructions. The non-participating Providers/Practitioners will also be given the name of the Member's PCP to arrange for follow-up services. If the non-participating Provider/Practitioner contacts the PCP directly, the PCP is responsible for coordinating the Member's care with the non-participating Provider/Practitioner.

If the non-participating Provider/Practitioner requests Care Management services, the call will be transferred to MHC's Care Management Department. The Case Manager will then arrange for any necessary follow-up care and will coordinate with the Member's PCP as necessary.

## Member Education

MHC provides Member education on STDs which includes disease-specific material, right to out-of-plan treatment, cost, assessment for risk factors, and the methodology for accessing clinical preventive services. Members are advised of these services in the Evidence of Coverage which is mailed at the time of enrollment and annually thereafter. MHC Health Education Department will send STD health education information to Providers/Practitioners upon request. See the section in this manual entitled "Health Education" for instructions on ordering materials and order forms.

## Provider/Practitioner Guidelines for STD Episodes

For the purposes of providing reimbursement to the Local Health Department for sexually transmitted diseases, an episode is defined based upon the specific sexually transmitted disease diagnosed as follows:

- Bacterial Vaginosis, Trichomoniasis, Candidiasis Initiation of treatment of vaginal or urethral discharge for symptoms and signs consistent with any one or a combination of these diagnoses is considered an episode, and one visit is reimbursable
- Primary or Secondary Syphilis - Initial visit and up to five additional visits for clinical and serological follow-up and re-treatment, if necessary, may be required for certain high-risk individuals. A maximum of six visits per episode is reimbursable. Documentation should include serologic test results upon which treatment recommendations were made

NOTE: Members who are found to have a reactive serology, but show no other evidence of disease, should be counseled about the importance of returning to the Provider/Practitioner for follow-up and treatment of possible latent syphilis. For female members of childbearing age who refuse to return to the Provider/Practitioner for their care, up to six visits are reimbursable for treatment and follow-up.

- Chancroid - Initial visits and up to two follow-up visits for confirmation of diagnosis and clinical improvement are reimbursable
- Lymphogranuloma Venereum, Granuloma Inguinale - Based upon the time involved in confirming the diagnosis and the duration of necessary therapy, a maximum of three visits is reimbursable
- Herpes Simplex - Presumptive diagnosis and treatment (if offered) constitute an episode, and one visit is reimbursable
- Gonorrhea, Non-Gonococcal, Urethritis and Chlamydia - Can often be presumptively diagnosed and treated at the first visit, often with single-dose therapy. For individuals not presumptively treated at the time of the first visit, but found to have gonorrhea or chlamydia, a second visit for treatment will be reimbursed
- Human Papilloma Virus - One visit reimbursable for diagnosis and initiation of therapy with referral to PCP for follow-up and further treatment
- Pelvic Inflammatory Disease - Initial visit and two follow-up visits for diagnosis, treatment, and urgent follow-up are reimbursable. Member should be referred to PCP for continued urgent follow-up after the initial three visits have been provided by the LHD

### Reimbursement

Participating Providers/Practitioners must bill MHC or the appropriate capitated IPA/Medical Group in accordance with their Provider/Practitioner agreement and all applicable procedures. If you are an individually contracted Provider/Practitioner rendering referred or authorized STD services, you are reimbursed at the lowest allowable Medi-Cal fee-for-service rate determined by DHCS if a specific rate has not been included in your Provider/Practitioner contract.

If the STD service is denied, for example, those patients not eligible under the Medi-Cal program, the claim will be sent to the Provider/Practitioner of service to protect the confidentiality of the Member.

If the member received STD services from a non-participating Provider/Practitioner and was required to pay out-of-pocket for the services, the Member must bill MHC or the affiliated health plan or IPA/Medical Group, according to their affiliation. The billing address is located on the back of the member's ID card.

## Human Immunodeficiency Virus (HIV) Testing and Counseling

MHC is responsible for promoting access to confidential HIV testing and counseling services available to its Members. MHC is to assist in the coordination of care and follow-up with the Local Health Department (LHD). MHC ensures coordination of

Medical Case Management and AIDS Waiver Case Management in developing a comprehensive approach to achieve healthy outcomes for MHC Members diagnosed with AIDS or symptomatic HIV disease. MHC is responsible for ensuring that its Members have access to appropriate and confidential HIV testing and counseling services and that Providers/Practitioners are reimbursed properly for services rendered.

MHC must also ensure that the collection, management, documentation, and release of information regarding HIV tests are handled in compliance with State and Federal laws and regulations. In addition, MHC must ensure the safety and confidentiality of its Members and staff. MHC's network of PCPs will perform or order confidential HIV testing, counseling, and follow-up services, when indicated. MHC Members may also receive HIV testing and counseling from a LHD or from other non-participating family-planning Providers/Practitioners.

## Local Health Department Coordination

MHC will collaborate with the Local Health Department for the following:

- To develop a Memorandum of Understanding (MOU) or a cooperative agreement addressing HIV testing and counseling services
- To coordinate the development of applicable policies and procedures
- To identify strategic opportunities to share resources, which maximize health outcomes
- To routinely communicate and facilitate optimal data and information exchange
- To ensure appropriate case management collaboration
- To work to resolve conflict at the local level

## Provider Training and Education

The Provider Services Department at MHC, in collaboration with the LHD, provides ongoing program education and training on HIV/AIDS services. This training provides information regarding the eligibility criteria for the AIDS Waiver Program. The MHC Provider Services Department maintains a list of all agencies providing AIDS Waiver Program services within the geographic region. The MHC Provider Services Department, in collaboration with the LHD, educates providers on the conditions that make an individual eligible for AIDS Waiver Program Services and the referral process.

## PCP Responsibilities

PCPs will routinely obtain a sexual history and perform a risk factor assessment for each of their Members. When appropriate, the Provider/Practitioner will screen for HIV infection with pre and post-test counseling. The PCP's initial disclosure of HIV test results to the Member can greatly affect the Member's knowledge of, and attitude about his/her condition. Prior to disclosing results, the PCP will assess the degree to which the Member, parent, or guardian is prepared to receive the results. The PCP will consider social, cultural, demographic, and psychological factors. Disclosure and counseling will always take place face-to-face. Immediate interventions may include assessing the Member for potential violence to him/herself or others, informing the Member of

available services, making referrals as necessary, and addressing the prevention of HIV. PCPs will educate the member regarding the State's HIV reporting requirements.

## Confidentiality

Counseling suggestions for the HIV positive members include:

- Providing information on available medical and mental health services as well as guidance for contacting sexual or needle-sharing partners. HIV-infected individuals should be counseled with regard to safe sex, including the use of latex condoms during sexual intercourse
- Describing the symptoms of common diseases that occur along with HIV and AIDS and when medical attention should be sought

Counseling suggestions for the HIV negative member may include:

- Not exchanging bodily fluids unless he/she are in a long-term mutually monogamous relationship with someone who has tested HIV antibody-negative and has not engaged in unsafe sex for at least six months prior to or at any time since a negative test
- Using only latex condoms along with a water-soluble lubricant
- Reminding never to exchange needle or other drug paraphernalia

## Reporting of Test Results

The reporting of HIV test results is not mandatory at this time. However, MHC requires Providers/Practitioners to report to the Department of Health Care Services and the County Health Officer whenever a patient is diagnosed with AIDS.

When reporting AIDS cases, the report is to include the name, date of birth, address, and social security number of the patient, the name of the Provider/Practitioner and clinic, and date of the patient's hospitalization as appropriate. An AIDS Adult Confidential Case Report Form is completed for Member's aged 12 and over.

## Screening and Testing

MHC requires the written consent of the patient prior to testing of patient's blood for antibodies to the causative agents of AIDS (HIV test). The patient's written consent is obtained by the Provider/Practitioner/designee. If blood is drawn at the Provider/Practitioner's office, the consent will be filed in the Member's medical records and the blood sample will be forwarded to the laboratory. Initial evaluation by the PCP will include a history and physical for all Members suspected of HIV infection. The member's history is key to differential diagnosis, primary prevention, and partner notification.

The following information should be obtained and documented in the Member's medical record:

- Member's sexual orientation

- Intravenous drug abuse history
- Transfusion history
- Incidents of sexual contact with a person(s) with AIDS or who subsequently developed AIDS
- History of homosexual or heterosexual promiscuity
- History of work-related exposure

The physical exam of the HIV Member will include all body systems and may prove to be entirely normal. Abnormal findings range from those completely non-specific to those highly specific for HIV infection. The Member may also present with symptoms to a large number of diseases that are commonly seen in HIV infected Members. A complete physical examination will be documented in the Member's medical record and will include:

- All body systems
- Visual acuity
- Oral cavity
- Gynecological exam

Common complaints may include:

- Systemic, i.e. fever, night sweats, weight loss, fatigue
- Gastrointestinal, i.e. nausea, vomiting, diarrhea, abdominal pain
- Respiratory, i.e. shortness of breath, cough, sinus pain
- Central nervous system, i.e. visual changes, headache, focal neurological deficits, seizures
- Peripheral nervous system, i.e. numbness, tingling, pain to the lower extremities
- Musculoskeletal, i.e. joint swelling and pain, muscle tenderness, proximal weakness

Initial laboratory evaluations may include, but are not limited to, any of the following when indicated:

- ELISA (Enzyme-Linked Immunosorbent Assay)
- Western Blot (after two positive ELISA tests)
- CBC and blood chemistry when transaminase
- Hepatitis B and C serology
- CD4 count - absolute and percent
- Baseline serology for cytomegalovirus (CMV) toxoplasmosis, and crytoantigen
- Septum culture
- Blood culture (if temperature is greater than 38.5 C)
- Wright-Giemsa stain
- Bronchoalveolar lovage
- Rapid Plasma Reagin (RPR) or Venereal Disease Research Laboratory (VDRL), i.e. rules out Syphilis, screen for other sexually transmitted diseases as indicated

## Confidentiality of Test Results

Results of blood tests to detect antibodies to the probable causative agent of AIDS (HIV test) are confidential and disclosure is limited. Results may be disclosed to any of the following persons without written authorization from the subject: To the subject of the test or the subject's legal representative, conservator, or to anyone authorized to consent to the test for the subject.

## Disclosure of Information

- Test results are placed in the medical record clearly marked "Confidential" for the use of the treatment team at MHC
- To a Provider/Practitioner of care who procures, processes, distributes, or uses human body parts donated pursuant to the Uniform Anatomical Gift Act
- The Provider/Practitioner who ordered the antibody test may, but is not required to, disclose
    - positive test results to a person reasonably believed to be a sexual partner or a person with whom the patient has shared the use of hypodermic needles (provided the Provider/Practitioner does not disclose identifying information about the test subject to the individual) or to the County Health Officer. He/she will not be civilly or criminally liable for doing so
- MHC providers/practitioners who disclose the results as outlined above are required to document such release, including first name and last initial of the person mentioned in the medical record of the patient, also giving the reason for the release, i.e. believed sexual partner, possible shared needles, etc.
- Prior to disclosing results to a third party, the Provider/Practitioner must first discuss the results with the patient, counsel the patient, and attempt to obtain the patient's voluntary, written consent and authorization to notify the patient's contacts
- If the Provider/Practitioner discloses the information to a contact, the Provider/Practitioner must refer that person for appropriate care

## Release of HIV Test Results

In all cases, except as mentioned previously, written authorization for release of HIV test results is required.

- Such disclosure includes all releases, transmissions, dissemination, or communications whether they are made orally, in writing, or by electronic transmission
- A valid authorization to release results of a blood test to detect antibodies of HIV is to be in writing and include to whom the disclosure must be made
- Written authorization is required for each separate disclosure of test results
- HIV test results will not be released pursuant to a subpoena for medical records unless accompanied by a court order directing the release
- The current applicable Release Form will be used for all releases under this section
- All requests for release of HIV test results will be verified for appropriateness

- Providers/Practitioners and employees of MHC are not permitted to remove the HIV test from the medical record or photocopy the HIV test results under any circumstances except as heretofore described

### Penalties for Improper Disclosure of Test Results

Health and Safety Code, Section 199.21, provides penalties for the negligent or willful disclosure of results of a blood test to detect antibodies to the probable causative agent of AIDS to any third party. The penalty applies if the disclosure is not authorized by the patient or by law.

- If an improper disclosure resulted from negligence there may be a fine up to $1,000 plus court costs
- If an improper disclosure resulted from a willful act, there may be a fine up to $5,000
- If an improper disclosure, whether negligent or willful, results in economic, bodily, and/or psychological harm to the subject of a test, the person who made the improper disclosure may be found guilty of a misdemeanor and fined up to $10,000 or be imprisoned in county jail for up to one year, or both, and may also be liable to the subject of the test for all actual damage caused, including economic, bodily, and/or psychological harm
- Any employee who releases information regarding HIV testing, whether results are positive or negative, in violation of this policy has also breached MHC's confidentiality policy and is subject to such disciplinary action as is warranted, up to and including dismissal from employment or service

### Continuing Care

As the disease progresses, and depending on any accompanying diseases the Member acquires, referrals to subspecialties will be initiated as needed. The PCP will consider management by an infectious disease specialist or HIV specialist when CD 4+ 200 cells u/L or the Member develops clinical AIDS. During the terminal phase of care, issues such as advanced directives, durable power of attorney, and hospital care will be addressed by the PCP. The Medical Case Manager will monitor, and coordinate care and services provided to HIV/AIDS Members by PCPs as well as any out-of-plan providers.

### Out-of-plan Providers/Practitioners

Members may access out-of-plan Providers/Practitioners for diagnosis of HIV/AIDS. MHC will reimburse contracted Providers/Practitioners at contracted rates. MHC will reimburse non-contracted, out-of-plan Providers/Practitioners at the Medi-Cal fee-for-service rate, unless otherwise negotiated. The diagnosis, counseling, and treatment of HIV/AIDS will be reimbursed if the Provider/Practitioner submits treatment records or documentation of the Member's refusal to release records along with billing information. Medical records obtained from out-of-plan Providers/Practitioners other than the Member's PCP will be shared with the PCP for the purposes of assuring continuity of care.

If a Member refuses to release the medical records required for billing, the out-of-plan Provider/ Practitioner must submit documentation of such refusal. Properly billed claims from out-of-plan Providers/Practitioners will be paid timely and in accordance with the Knox-Keene Act (amended).

## Tuberculosis (TB) Screening and Treatment and Directly Observed Therapy (DOT)

The estimated number of persons in the United States with latent tuberculosis (TB) infection is 10 to 15 million. Studies have shown the treatment of such patients with at least six months of antibiotics can significantly reduce progression to active tuberculosis. Preventive treatment is ninety percent effective when the patient compliance is good. Tuberculosis is associated with considerable morbidity from pulmonary and extra pulmonary symptoms.

Directly Observed Therapy (DOT) Services are offered by Local Health Departments to monitor those patients with active tuberculosis who have been identified by their Provider/Practitioner as at-risk for non-compliance with treatment regimen. DOT is a measure both to ensure adherence to tuberculosis treatment for at-risk Members who either cannot or likely will not follow the treatment regimen and to protect the public health.

MHC and Providers/Practitioners coordinate and collaborate with Local Health Departments (LHDs) for TB screening, diagnosis, treatment, compliance, and follow-up of members. MHC's guidelines for TB screening and treatment follow the recommendations of the American Thoracic Society (ATS), Centers for Disease Control and Prevention (CDC), and the Advisory Committee for Elimination of Tuberculosis (ACET). MHC coordinates with LHDs for the provision of Directly Observed Therapy (DOT), contact tracing, and other TB services. Members meeting the mandatory criteria for DOT are identified and referred to LHDs.

TB screening and treatment services for Members are covered responsibilities under the Two-Plan Model Contract. MHC collaborates with LHDs to control the spread of TB and to facilitate access to TB treatment. MHC coordinates with LHDs to establish an effective coordination of care to achieve optimum clinical outcomes for members. Early diagnosis, immediate reporting to LHDs, and appropriate TB treatment are critical to interrupting continued transmission of TB. MHC informs PCPs that they must report known or suspected cases of TB to the LHDs TB Control Program Office within one day of identification, per Title 17, CCR, Section 2500. PCPs will coordinate and collaborate with LHDs for TB screening, diagnosis, treatment, compliance, and follow-up of MHC Members. MHC medical policy guidelines for TB screening and treatment follow the recommendations of the American Thoracic Society ATS, CDC, and the ACET. MHC will coordinate with LHDs for the provision of Directly Observed Therapy (DOT), contact tracing, and other TB services. MHC Members meeting the mandatory criteria for DOT are identified and referred to LHDs. MHC will direct diagnose Class III and Class V TB cases to the applicable LHD for treatment. The PCP is responsible for coordination of

care with the LHD and for meeting any additional health care needs of the Member, unrelated to TB services.

## Tuberculosis Control Strategy

MHC's TB control strategy for members include the following: continued collaboration, communication, and contracting with the LHDs in the areas of public health coordination, community education/training, Provider/Practitioner and Provider/Practitioner staff education/ training, referral process, screening/ treatment, DOT, and case management processes. The control strategy includes the following:

- Communicating with the LHDs in order to facilitate an effective TB prevention, screening, and treatment process
- Identifying and reporting of TB cases to LHD
- Providing educational programs to the Members residing in various counties
- Providing education and resources to Provider/Practitioners and Provider/Practitioner's staffs regarding the prevention, screening, identification, and treatment of TB
- Providing MHC Members diagnosed with TB with early and appropriate treatment Promoting compliance with treatment programs
- Preventing the spread of TB

## Screening for Tuberculosis Infection

Screening for TB is done to identify infection in Members at high-risk for TB who would benefit from therapy. Screening is also done to identify Members with active TB disease who need treatment. An assessment of risk for developing TB must be performed as part of the initial health assessment required within 90 days of enrollment with MHC. MHC collaborates with the LHD TB Control Programs to identify refugees who are possible candidates for local refugee health clinic services.

## Tuberculosis Risk Assessment in Adults

For adult Members, an assessment of risks for developing TB will be performed as part of the initial health assessment required to be conducted within 90 days of enrollment. TB testing must be offered to all individuals at increased risk of TB unless they have documentation of prior positive test results or currently have TB disease. High-risk individuals include:

- Persons with medical risk factors associated with TB
- Immigrants from countries with high TB prevalence
- Alcoholics
- Drug users
- Residents of long-term care facilities

## Tuberculosis Risk Assessment in Children

For MHC Members under age 21, assessment for risk factors for developing TB and tuberculin skin testing must be conducted in compliance with current American Academy of Pediatric Requirements. The risk factors include the following:

- Those who have had contact with a person(s) with infectious TB
- Those who are from, or who have parents who are from, regions of the world with a high prevalence of TB
- Those with abnormalities on chest x-ray suggestive of TB
- Those with clinical evidence of TB
- Children who are HIV-seropositive
- Those with immunosuppressive conditions
- Those with other medical risk factors such as Hodgkin's Disease, lymphoma, diabetes mellitus, chronic renal failure, and/or malnutrition
- Incarcerated adolescents
- Children who are frequently exposed to the following adults: HIV infected individuals, homeless persons, users of intravenous and other street drugs, residents of nursing homes, and migrant farm workers

## TB Skin Testing Protocols

Mantoux tuberculin skin testing is the standard method of identifying persons infected with TB. The Mantoux test will be given and read by qualified staff. Steps of tuberculin skin testing are as follows:

- TB testing must be offered to all individuals at increased risk of TB unless they have documentation of prior positive test results or currently have TB disease
- The screening test to be used is the Mantoux tuberculin test. The multi-puncture test must not be used
- Trained personnel must read the skin test results and record the result in millimeters
- Tuberculin testing will be done by injecting five Tuberculin Units (TU) of PPD (0.1 ml) intradermally
- Previous BCG Vaccination is never a contraindication to tuberculin testing
- Members with a history of previous positive PPD (Mantoux) should not be retested
- Interpretation of the test result: The test will be read 48 to 72 hours after the injection. In the general Member population, a reaction of greater than or equal to 10mm of induration will be considered a positive test
- Members with a positive skin test will have a chest x-ray to exclude pulmonary TB
- Members with an asymptomatic infection (positive skin test, but no evidence of disease on chest x-ray) will be treated with INH alone. In infants and children, recommended duration of INH is nine months. Note: INH is given daily, 10 mg per kg, in a single dose, or 300 mg/day in adults
- Children receiving INH do not need Pyridoxine supplements unless they have nutritional deficiencies.

- Pyridoxine is recommended for children and adolescents on meat or milk deficient diets, or with other nutritional deficiencies, breast-feeding infants, and women during pregnancy
- Immunizations - Members who are receiving treatment for TB may be given measles vaccine or other live virus vaccines as otherwise indicated unless they are receiving steroids, are severely ill, or have specific vaccine contraindications
- Adults treated with INH should have baseline liver function tests (LFT) done. LFTs should be repeated monthly. In children, the incidence of hepatitis during INH therapy is so low that routine determination of LFTs is not recommended
- Adults under age 35 should be treated with INH for nine months if they have a positive PPD and a negative chest x-ray. In members 35 years and over, the risk of hepatic toxicity from INH outweighs the risk of progression of TB and is not recommended

The definition of a positive tuberculin skin test is as follows:

- Greater than or equal to five mm for persons known or suspected to have HIV infections
- Contact with an infectious case of TB
- Person with an abnormal chest x-ray, but no evidence of active TB
- Greater than or equal to 10 mm, all persons except those listed above
- Greater than or equal to 15 mm. In California, this cut off is not recognized by Public Health Departments

Tuberculin skin tests are not recommended for persons at low risk for TB infection. Tuberculin skin test conversion is defined as an increase of at least 10 mm of induration from below 10 mm to greater than or equal to 10 mm within 24 months of a documented negative to a positive tuberculin skin test. If the test is positive, a chest x-ray must be done. Since a positive TB test does not necessarily indicate the presence of active TB disease, an individual showing a positive TB test requires further screening with other diagnostic procedures.

If the member does not return to have his/her skin test read, follow-up will be conducted by the PCP according to the missed appointment policy and process with documentation of steps taken in the Member's medical record.

## Classification of TB

| CLASS | TYPE | DESCRIPTION |
|---|---|---|
| 0 | TB exposure; Not infected | No history of exposure Negative reaction to tuberculin skin test |
| I | TB exposure;<br>No evidence of infection | History of exposure Negative reaction to tuberculin skin test |
| II | TB infection; No disease | Positive reaction to tuberculin skin test<br>Negative bacteriologic studies (if done)<br>No clinical or radiological evidence of TB |

| CLASS | TYPE | DESCRIPTION |
|---|---|---|
| III | Current TB disease | *M. Tuberculosis* cultured (if done) OR Positive reaction to tuberculin skin test AND Clinical or Radiological evidence of current disease |
| IV | Previous TB disease | History of episode(s) of TB OR Abnormal but stable radiograph finding's Positive reaction to the tuberculin skin tests Negative bacteriologic studies (if done) AND No clinical or radiographic evidence of current disease |
| V | TB suspected | Diagnosis pending |

## Standard Initial Regimes

All TB cases, TB Class III, or TB Class V individuals in California should be started on a four-drug regimen of INH, RIF, Pyrazinamid (PZA), and Ethambutol (EMB), unless contra- indicated. The treatment may be given in three ways:

- Daily treatment regime: Drugs should be given together; dosages should not be split
- Bi-weekly regime: Four drug therapies, administered daily for two weeks and then two times a week for six weeks. This sequence should then be followed by therapy with INH and RIF given two times a week for sixteen weeks
- Thrice weekly treatment regime: Three times weekly from the beginning; all four drugs must be given for six months

For number one above, EMB should be continued until drug susceptibility results are available and resistance to INF and RIF has been excluded. PZA is continued for the first two months. RIF and INH are continued for a total of six months. Intermittent therapy (see above) should only be given to directly observed therapy members. If cultures remain positive beyond two months of treatment, therapy should be prolonged. Ideally, treatment should be continued at least six months after the culture converts to negative.

## Case Management

Management of members with suspected or diagnosed TB will be referred to the Case Management program of MHC or its affiliated health plan. The Case Management staff will notify the Local Health Department TB Control Program of the designated MHC Provider/Practitioner or staff responsible for coordination of TB care with the LHD TB Control Program. MHC will promptly notify the LHD TB Control Program of any changes in the Provider/Practitioner assigned to a confirmed or suspected TB case within seven days.

The PCP must respond to requests for information from the LHD TB Control Program in a timely manner and will consult with the LHD TB Control Program about treatment recommendations and protocols, as needed.

The Case Management staff, PCP, and the LHD TB Control Program collaborate in identifying barriers to member compliance with self-administered treatment. Fixed-dose combination drug preparations will be available for members on self-administered therapy, and they are strongly encouraged for treatment of adults to promote compliance.

As agreed with the Local Health Department, the LHD TB Control Program will assign a TB Case Manager (TBCM) who will:

- Assess risk of transmission within two working days of case notification
- Visit the member within seven working days, depending on transmission risk factors
- Initiate contact investigations, when indicated
- Assess and address potential barriers to treatment adherence
- Verify initial information and collect additional information needed to complete the TB case report
- Visit the member as needed to assess and ensure treatment adherence
- Promptly notify MHC of assignment or change of the TBCM
- Respond to information requests from the PCP in a timely manner

## Reporting

PCPs will comply with all applicable State laws and regulations pertaining to the reporting of confirmed and suspected TB cases to the LHD. The PCP will report known or suspected cases of TB to the LHD TB Control Program within one day of identification. Reporting will be done in accordance with MHC Confidential Morbidity Reporting policy.

PCPs will promptly submit treatment plans, including dosage changes, to the LHD with updates at regular intervals as requested by the LHD until treatment is completed. * PCPs will notify the LHD when there are reasonable grounds to believe that a Member has ceased treatment. Such grounds include Member's failures to keep appointments, relocation without transferring care, or discontinuation of care.

## The LHD Local Health

Officer may require MHC Providers/Practitioners at any time to report any clinical information deemed necessary including the prompt reporting of drug susceptibility by the Local Health Officer to protect the Member's health or the health of the public.

*NOTE: This is not applicable if the LHD is serving as the primary treatment center for the TB Member.

## Referrals

The PCP will identify Class III and Class V TB cases and will route a copy of the referral form to the LHD TB Officer. A copy of the referral form will also be sent to the MHC Utilization Management Department.

The PCP may make a referral to MHC or the subcontracted affiliated plan's Utilization Management Department for case management of services for Members who are repeated no-shows for appointments. If the Case Manager determines that the Member is considered lost to medical follow-up, the health plan's Case Manager will notify the LHD.

Members diagnosed with TB must be referred by the PCP to the LHD and the health plan's Utilization Management Department.

The following Members may be appropriate for referral to the LHD and the health plan's Utilization Management Department:

- Substance abusers
- Persons with major mental health disease
- Elderly Persons
- Homeless Persons
- Formerly incarcerated person
- Persons with slow sputum conversion
- Persons with slow/questionable clinical adherence
- Persons with adverse reaction to TB medication
- Persons with poor understanding of their disease process and management
- Persons with language and/or cultural barriers

## Contact Investigation and Treatment

PCPs will cooperate with the LHD TB Control Program in conducting contact and outbreak investigations involving MHC members. The Case Management Department will be available to facilitate, and if necessary, direct the coordination efforts between LHD TB Control Program and the contracted Provider/Practitioners.

Contracted Provider/Practitioners must provide appropriate examination treatment to MHC Members identified by the LHD as contacts in a timely manner, usually within seven days. Examination reports will be reported back to the LHD in a timely manner. PCPs and/or the Case Management Department will promptly notify the LHD when contacts of MHC members are referred to the LHD TB Control Program for examination.

## Educational Material

Educational material may be obtained for Members from various resources including, but not limited to:

- MHC Health Education Department Telephone: 562-499-6191 ext. 127524

- American Academy of Pediatrics, “Patient Medication Instructions: Isoniazid” Telephone: (800) 433-9016
- American Lung Association, “Facts about Tuberculosis”. Telephone: (800) 586-4872
- Krames Communications, “Understanding Tuberculosis”. Telephone: (800) 333-3032
- American Thoracic Society, 61 Broadway, New York, 10006-2755. (212) 315-8600
- U.S. Centers for Disease Control and Prevention/National Centers for Prevention Services
- Division of Tuberculosis Elimination, 1600 Clifton Rd. NE Mail Stop E, Atlanta, Georgia 30333, Telephone: (404) 639-8135

The MHC Health Education, Provider Services, and Care Management Departments will cooperate with the LHD TB Control Program to make health education resources available to MHC Members, Provider/Practitioners, and Provider/Practitioner’s staff. This includes education to Providers/ Practitioners and Provider/Practitioner’s staff on how to perform and interpret TB screening tests.

Directly Observed Therapy (DOT) for TB is not a covered MHC service but is offered directly by the LHD.

### DOT Referrals to LHDs

When a PCP identifies a TB patient who is at-risk for compliance with his or her treatment regime, the PCP will fax a copy of the DOT referral form obtained from the LHD to the Control Officer. The LHD must be notified when the PCP has reasonable grounds to believe that a patient has ceased treatment, failed to keep an appointment, has adverse drug reactions, relocated without transferring care, and/or has discontinued care.

The following members with diagnosed TB must be referred for DOT services:

- Members having multiple drug resistance (defined as resistance to INH and RIF)
- Members whose treatment has failed
- Members who have relapsed after completing a prior regime
- Children
- Adolescents
- Noncompliant individuals

Members with the following conditions should be considered for referral for DOT:

- Substance abusers
- Persons with major mental health disease
- Elderly Persons
- Homeless Persons
- Formerly incarcerated person
- Persons with slow sputum conversion
- Persons with slow/questionable clinical adherence

- Persons with adverse reaction to TB medication
- Persons with poor understanding of their disease process and management
- Persons with language and/or cultural barriers

### Follow-up Care

PCPs are required to coordinate with the LHD TB Control Officer and to provide follow-up care to all Members receiving DOT services. PCPs should inform the LHD TB Control Program of any changes in the Member's response to the treatment or drug therapy. PCPs will receive a periodic report from the LHD TB Control Program, which advises them of each Member's treatment status. The LHD TB Control Program will send a copy of the Member's medical record and final status report upon completion of the DOT services to the PCP.

The PCP will arrange for the Member to receive a follow-up appointment in order to develop a follow-up treatment plan. The PCP will follow-up if the patient is a no-show for the scheduled appointment through telephone or letter and will document such follow-up effort in the Member's medical record. The PCP will notify the LHD TB Control Program if the Member continues to miss follow-up appointments.

# 13. HEALTHCARE SERVICES: PEDIATRIC & CHILD HEALTH SERVICES

## Children's Preventive Services Including Early and Periodic Screening Diagnostic and Treatment (EPSDT) Services

### Children's Preventive Services

The Children's Preventive Services program is a preventive well-child screening program for children, adolescents and young adults who are under 21 years of age. The Early Periodic Screening Diagnostic and Treatment (EPSDT) services (formerly called Child Health and Disability Prevention—CHDP) program provides complete health assessments for the early detection and prevention of disease and disability in children. The program ensures that eligible children receive periodic health assessments and have access to ongoing health care from a medical home.

### Physician Certification (Suggested)

CHDP/EPSDT certification is provided at no cost by the county CHDP/EPSDT Program and usually involves an interview and office evaluation. Non-CHDP certified physicians may contact the State directly or the MHC Provider Services Department at (855) 322-4075 for assistance to help facilitate this process. We urge any provider who cares for pediatric, adolescent and young adult members under age 21 to attain this certification. This ensures your office is recognized as a provider of quality for pediatric patients.

### Appointments

Well child preventive care appointments with PCPs should be scheduled within seven working days of the request.

### Components of Health Assessment

A CHDP/EPSDT provider is expected to conduct a complete health assessment on all of the following:

- Health history
- Developmental assessment
- Unclothed physical "head-to-toe" examination
- Vision testing
- Hearing testing
- A Dental assessment of mouth, teeth, and gums
- A Nutritional assessment
- Laboratory screening tests appropriate to age/sex, (e.g. anemia, diabetes and urinary tract infections)
- Tuberculosis screening, with Tuberculin testing as appropriate
- Sickle cell trait test, when appropriate

- Blood lead test per California state guidelines
- Immunization(s)
- Anticipatory guidance as delineated in the California Health Assessment Guidelines
- Appropriate health education, including the harmful effects of using tobacco products and exposure to secondhand smoke

Members should be referred annually for routine dental care starting at one year of age. A provider can directly refer the Member to a dentist or call (800) 322-6384.

## Referrals and Coordination of Care

One of the goals of the CHDP/EPSDT program is to identify any medical, dental, nutritional and developmental problems that a child may have and intervene before the problems become severe. Once a medical, dental, nutritional or developmental problem is identified during the CHDP/EPSDT health exam, the child may need further diagnosis and/or treatment of that problem. If the child needs specialty care, such as from an optometrist or a dentist, the CHDP/EPSDT provider is obligated to make the referrals to assist the family to obtain the care their children need. The PCP is responsible for the supervision of practitioner extenders, ongoing care, and the coordination of care for all services that the Member/child receives. Plan Pediatric Medical Case Managers are available to provide care coordination if indicated and requested by the PCP.

MHC will provide transportation to these appointments at the Member's request. Assistance with arrangement for transportation is available through the health plan contracted vendor, American Logistics (844) 292-2688.

## Obtaining Consent

Physicians must obtain the voluntary written consent of the Member (if over 18 years) or parent/guardian (if under 18 years) before performing a CHDP/EPSDT exam. Consent is also required for any release of information.

If the member or parent/guardian refuses to have the exam or any portion of the exam performed, this information must be documented in the Member's medical record.

## Certification for School Entry

California State law requires that a child entering first grade must provide their schools with a certificate documenting receipt of a health assessment or a waiver of the assessment signed by the parent or a legal guardian. A child's personal physician may certify the individual for school entry if there is documentation that the physician has performed a physical examination and provided ongoing care during the 18-month period prior to or within 90 days following entrance into the first grade. The medical care must have included all applicable health assessment procedures. Providers should supply the parent or guardian of a child entering kindergarten or the first grade with a Report of Health Examination for School Entry Form (PM 171A) to show that the child has received the appropriate health assessments. Providers must supply certifications

for all children whether or not the CHDP/EPSDT program reimburses for the health assessment.

The CHDP/EPSDT program and local schools urge parents to schedule a health assessment for their child upon entry into kindergarten. If the parent or guardian refuses a health assessment, the parent or guardian must submit a waiver to the school.

### Follow-Up for Missed Appointments

For Members who are a "no-show" at the time of their appointment(s), the Member (parent/guardian) should be followed-up with a telephone call and, if necessary, a letter from the physician's office to schedule another appointment. Documentation of the telephone call or a copy of the letter must be maintained in the Member's medical record.

All physicians who deliver care to eligible CHDP/EPSDT Members must submit services through encounter or claims forms.

An encounter or claim must be completed for each child who receives a CHDP/EPSDT health assessment. All encounters or claims forms must be complete and accurate. Incomplete or inaccurate encounters or claims forms will be rejected or denied.

## Immunizations

The provision of immunizations to children is an essential component of the comprehensive periodic health assessment required for Members under age 21. PCPs are responsible for the administration of immunizations to their patients. Immunization services may be accessed during any PCP visit. MHC does not require rescheduling of visits for immunizations for immediate evaluation unless the child has a medical contraindication to receiving immunizations at the time of his/her visit to the PCP. Local Health Departments (LHDs) may also administer immunizations to MHC Medi-Cal Members. Go to www.cdc.gov to view the childhood immunization requirements. A sample Vaccine Administration Record for Children and Teens can also be found in Section 19, Exhibit 19M. (See below regarding the federal Vaccines for Children program and provision of vaccines for Medi-Cal members).

Additional information addressing protocols for care coordination and patient follow-up including for well childcare can be found in the Adult Preventive Care and Children's Preventive Services sections of this Manual.

MHC Preventive Care Guidelines (PHGs) are derived from recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians, and others. They are updated annually. Age-specific PHGs for members are available on

the MHC webpage at: www.MolinaHealthcare.com. You may request a copy by contacting Provider Services at (888) 665-4621.

## Participating Providers/Practitioners

PCPs are expected to be available to administer immunizations during routine office hours. The PCP also has the responsibility of updating the immunization card supplied by the Local County Health Department. Members are encouraged by MHC to set up evaluations for initial health assessments and immunizations during the first days 120 days of enrollment with MHC. MHC sends new members welcome and reminder letters advising them of this service. Members should also receive written notice from the PCP to prompt members to come in for needed immunizations.

At each visit the PCP will inquire if the Member has received immunizations from another Provider/Practitioner. The PCP will also educate Members regarding their responsibility to inform their PCP if they receive immunization elsewhere, i.e., non-plan Providers/Practitioners, LHD, etc. When a Member experiences complication (e.g., infection or abscess), Members should contact their PCP for follow-up care just as they would with any other medical condition or concern.

Upon request, the LHD will provide technical assistance, training, and material related to immunizations for MHC Providers/Practitioners. LHDs will assist MHC in their outreach efforts by conducting public education campaigns regarding immunizations. Provider/Practitioner bulletins will include updates of information on immunizations.

Providers/Practitioners are expected to participate in the Vaccines for Children (VFC) Program VFC: Vaccines for Children Program | CDC . This is a Federally funded program that provides free vaccines for Medi-Cal and other eligible children and distributes immunization updates and related information to participating Providers/Practitioners. VFC provides the vaccine to PCPs; MHC will reimburse PCPs for vaccine administration.

PCPs are expected to maintain a current medical record on all members, addressing applicable immunizations, notifications, and immunization services provided by an out-of-plan Provider/Practitioner. The PCP will cooperate with the out-of-plan Provider/Practitioner when requested to share Member's immunization history. The PCP will document diligently all efforts in assessing the actual immunization status of the MHC member prior to any immunization services. PCPs are also expected to participate in the state immunization reporting network, California Immunization Registry CAIR. This registry can be used to check patient immunization status as well as enter immunizations that the PCP administers.

## Local Health Department (LHDs)

In accordance with Department of Health Care Services (DHCS) guidelines, MHC will reimburse LHDs for certain immunizations and services without prior authorization.

MHC requires that the LHD contact the Member's PCP or Molina's Member Services Department to confirm eligibility and benefits before administering the immunization.

## Member Identification

All Members are encouraged to maintain a current immunization status. Members requiring immunizations are identified through the following sources:

- Initial health assessments
- Primary care practitioners (PCPs) and specialists
- Quality Improvement Department
- Member Services Department
- Utilization Management Department
- Emergency room/urgent care facilities
- Local Health Departments
- Claims and encounter data
- Provider Service Department through Provider/Practitioner inquiries
- Members
- Health Education Department
- Schools

## Member Outreach and Education

MHC's Member outreach and health education efforts for both pediatric and adult immunization concentrate on informing Members about the necessity of immunizations. The MHC Health Education Department distributes Member education via a Member newsletter, website and other educational materials that include information promoting immunizations. The PCP is responsible to ensure the Member is up to date with immunizations.

## Promoting Access to Care

MHC promotes appropriate access to care as well as immunizations by offering Provider/ Practitioner educational materials and the Provider Online Directory on www.MolinaHealthcare.com. Members also have access to MHC's 24-hour Nurse Advice service, which includes answering questions on immunizations, and other health concerns.

## Reporting of Vaccine Preventable Diseases

MHC will assist LHDs in educating Providers/Practitioners, including laboratories, about their responsibilities to report vaccine-preventable (and other infectious) diseases according to California Health and Safety Code regulations.

The PCP and health plans will cooperate and assist LHDs in informing Providers/Practitioners of reported disease outbreaks and implementation of control procedures.

Please refer to MHC Policy and Procedure titled QM 41, Confidential Morbidity Reporting to Public Health, for details. This report can be obtained by contacting the Provider Services Department of MHC. Information regarding Confidential Morbidity Reporting is located in the Tuberculosis section of this Manual.

### Public Health Coordination

MHC has collaborated with Local Health Departments to:

- Negotiate the Memorandum of Understanding
- Develop and coordinate policies and procedures
- Provide in-service training to internal staff and contracted Providers/Practitioners

## Vaccines for Children Program

### Vaccines for Children (VFC)

The provision of immunizations to children is an essential component of the comprehensive periodic health assessment required for Medi-Cal Members under age 21. Medi-Cal Providers/Practitioners are expected to participate in the Vaccines for Children (VFC) Program. VFC: Vaccines for Children Program | CDC This Federally and State funded program furnishes free vaccines in bulk to enrolled Providers/Practitioners. All Medi-Cal children are eligible to receive these vaccines.

### Becoming a VFC Provider

Download and review the program's Provider Enrollment Packet from www.eziz.org. Complete enrollment forms and submit them to VFC. You may also FAX your request to VFC's Customer Service Center at (877) 329-9832 to request paper-based Provider Enrollment Packets. Be sure to include the name and mailing address of the person to whom the packet should be sent. For more details see our enrollment section at: www.eziz.org.

Once your application is received, VFC reviews the paperwork for completion, conducts license verifications, and assigns the enrollment request to a VFC Representative in your region to conduct a New Provider Enrollment Site Visit. Once a New Provider Enrollment Site Visit is completed, and VFC has verified your practice is ready to receive and store VFC-supplied vaccines (ensures vaccine storage units meet program requirements), VFC will assign your practice a unique Provider Identification Number (PIN), complete your enrollment, and issue a welcome letter to confirm enrollment. For more information on California VFC Program, visit the website at: www.eziz.org or contact VFC at: Phone: (877) 243-8832; Fax: (877) 329-9832.

## Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a Medi-Cal benefit for children and youth under the age of 21. The EPSDT benefit provides a

comprehensive array of preventive, diagnostic, and treatment services. Molina is required to provide coverage of any services listed in section 1905(a) of the federal Social Security Act to children who are eligible for EPSDT services when the services are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. These medically necessary services must be provided whether or not they are normally covered for adults under the usual Medi-Cal benefit.

Services must also be provided when medically necessary to prevent disease, disability, and other health conditions or their progression, prolong life, and promote physical and mental health and efficiency. The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child. Molina will consider the child's long-term needs, not just what is required to address the immediate situation. Molina considers all aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders. The EPSDT benefit is more robust than the state Medi-Cal benefit package provided to adults and is designed to ensure that eligible children receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. Molina providers need to follow Plan Prior Authorization guidelines, and the Authorization Process, as long as the guidelines do not contradict or prove to be more restrictive than the federal statutory requirement.

Appropriate EPSDT services are to be initiated in a timely manner, as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow- up.

EPSDT services include the following:

- Screening services are provided "at intervals that meet standards of medical and dental practice, and at such other medically necessary intervals to determine the existence of physical or mental illnesses or conditions." Screening services must at a minimum include: a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level taking into account age and risk factors); and health education (including anticipatory guidance). In addition, screening services include any other encounter with a licensed health care provider that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition
- Vision services provided at intervals which meet reasonable standards of medical practice and that shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses
- Dental services provided at intervals which meet reasonable standards of dental practice to determine the existence of a suspected illness or condition and at a minimum includes treatment for relief of pain and infections, restoration of teeth, and maintenance of dental health

- Hearing services provided at intervals which meet reasonable standards of medical practice to determine the existence of a suspected illness or condition and, at a minimum, includes diagnosis and treatment for defects in hearing, including hearing aids
- Other necessary health care, diagnostic services, treatment, and measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the California state plan or are covered for adults

Members under the age of 21 must receive EPSDT screenings designed to identify health and developmental issues, including Autism Spectrum Disorder (ASD) as early as possible. Molina is responsible for providing medically necessary BHT services for children who meet eligibility criteria for services. The EPSDT benefit provides all medically necessary services as described under Title 22, CCR, Section 51184 and Title 9, CCR, Sections 1820.205 and 1830.210 that may be referred to as "EPSDT Supplemental Services" in the Molina contract with the Department of Health Care Services (DHCS).

EPSDT Supplemental Services:

- Molina is required to cover and ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services for individuals under the age of 21 including EPSDT Supplemental Services. The EPSDT benefit includes case management and targeted case management services designed to assist children in gaining access to necessary medical, social, educational, and other services. Molina must ensure that comprehensive case management is provided to each beneficiary. Molina maintains procedures for monitoring the coordination of care provided to beneficiaries, including but not limited to all medically necessary services delivered both within and outside the Molina provider network
- Dental services are carved out. The PCP will include dental screenings as a part of the initial health assessment. Dental screening/oral health assessment must be performed as part of every periodic assessment. Members will be referred to appropriate Medi-Cal dental (Denti-Cal) providers. Molina will provide prior authorization for medical services required in support of dental procedures
- Molina must ensure that the criteria set forth in Title 22, CCR, Section 51340.1 are met when approving the following EPSDT services: hearing services, onsite investigations to detect the source of lead contamination, and pediatric day health care services. In addition, MCPs must comply with the Americans with Disabilities Act mandate to provide services in the most integrated setting appropriate to the individuals
- Speech therapy, occupational therapy, and physical therapy services are exempt from standard Medi-Cal benefit limitations. Molina provides speech therapy, occupational therapy, and physical therapy services when medically necessary to correct or ameliorate defects discovered by screening services, whether or not such services or items are covered under the state Medi-Cal plan

- Molina will provide appointment scheduling assistance and necessary transportation, including non- emergency medical transportation (NEMT) and non-medical transportation (NMT), to and from medical appointments for medically necessary services. Molina is also responsible for providing NMT to obtain covered Medi-Cal medical, dental, mental health and substance use disorder services. Molina will make the best effort to refer and coordinate NEMT for non-covered services. In addition, Molina must refer for and coordinate NMT to and from appointments for all Medi-Cal services that are carved-out, including specialty mental health, substance use disorder, dental, and any other services provided through the Medi-Cal fee-for-service (FFS) delivery system. Molina will provide transportation for the parent or guardian when the member is a minor. Molina does not transport unaccompanied minors except in the event that the appointment is for a service that does not require parental consent, as defined by state and federal law

For members under the age of 21, the PCP will:

- Follow The Patient Protection and Affordable Care Act (ACA) mandated use of the most current American Academy of Pediatrics periodicity schedule and Bright Futures guidelines and anticipatory guidance when delivering the EPSDT benefit, including but not limited to, screening services, vision services, and hearing services
- Provide all age specific assessments and services
- Provide screening, preventive, and medically necessary diagnostic and treatment services
- The PCP may request Prior Authorization for EPSDT supplemental services through the Molina Prior Authorization process. Any contracting Molina practitioner, including a physician, clinic, home health agency, medical equipment supplier, psychologist, speech therapist, or audiologist, may provide EPSDT supplemental services

## Molina Pediatric Case Management Services

Molina Pediatric Case Management Department will assist in the coordination of EPSDT Supplemental Services, including carve-out services:

- Molina Pediatric Case Management Department will assist in making referrals to carve-out programs such as CCS, Regional Center, HCBS waiver program, or practitioner of other “carve-out” services such as dentists or mental health practitioner
- Where another entity—such as a local education agency (LEA), Regional Center, or local governmental health program—has overlapping responsibility for providing services to an individual under the age of 21, Molina Pediatric Case Management Department will assess what level of medically necessary services the individual requires, determine what level of service (if any) is being provided by other entities, and then coordinate the provision of services with the other entities to ensure that Molina and the other entities are not providing duplicative services
- Molina Pediatric Case Management Department will assist with appointment scheduling assistance and necessary transportation, including NEMT and NMT, to and from medical appointments for the medically necessary services that Molina is

responsible for providing, pursuant to contracts with DHCS. In addition, Molina must refer for and coordinate NMT to and from appointments for all Medi-Cal services that are carved-out, including specialty mental health, substance use disorder, dental, and any other services provided through the Medi-Cal fee-for-service (FFS) delivery system

## California Children's Services (CCS) Program

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic and complex medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. The care is delivered by CCS paneled Providers and Practitioners.

MHC Primary Care Practitioners are responsible for performing all preliminary testing and examination to determine a member's diagnosis or condition and for sufficiently documenting the information to support the diagnosis in the member's medical record. In accordance with CCS eligibility criteria, potentially eligible members are referred by the PCP or specialist physician to the CCS program. Providers are to refer a member to the CCS Program within one working day of a suspicion of the presence of a CCS eligible condition. Any Provider/Practitioner, family member, or other interested party may make a referral to CCS.

The PCP is responsible to provide all Medically Necessary Covered Services for the member's CCS eligible condition until CCS eligibility is confirmed. Once eligibility for the CCS program is established for a Member, the PCP shall continue to provide Basic Case management, and all Medically Necessary Covered Services that are unrelated to the CCS eligible condition. If the local CCS program does not approve eligibility, the PCP remains responsible for the provision of all Medically Necessary Covered Services to the Member.

### Eligibility Criteria

Medical eligibility for CCS is based on a combination of state approved diagnostic and procedural coding categories and the presence of certain qualifying conditions. The listing of state-approved diagnostic and procedural coding categories is a guide for participating Providers/Practitioners to identify potential CCS eligible conditions.

### Who Qualifies for CCS?

The program is open to anyone who:

- Is under 21 years old;
- Has a medical condition that is covered by CCS;
- Is a resident of California;
- And has one of the following:

- family income of $40,000 or less
- out-of-pocket medical expenses expected to be more than twenty percent of family's adjusted gross income
- a need for an evaluation to find out if there is a health problem covered by CCS
- was adopted with a known health problem that is covered by CCS
- a need for the Medical Therapy Program
- Medi-Cal, with full benefits

## What Medical Conditions Does CCS Cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are complex and chronic; they are usually physically disabling or require medical, surgical, or rehabilitative services. Listed below are categories of medical conditions that may be covered and some examples of each:

- Infectious Disease—HIV/AIDS
- Neoplasms—Most malignancies
- Endocrine, Nutritional, and Metabolic Diseases, and Immune Disorder--Diabetes
- Diseases of the Blood and Blood-Forming Organs--Hemophilia
- Diseases of the Nervous System—Cerebral Palsy
- Diseases of the Eye--Blindness
- Diseases of the Ear and Mastoid--Deafness
- Diseases of the Circulatory System—Congenital Heart Disease needing surgery
- Diseases of the Respiratory System—Bronchopulmonary Dysplasia
- Diseases of the Digestive System—Ulcerative Colitis
- Diseases of the Genitourinary System—Kidney Failure
- Diseases of the Skin and Subcutaneous tissue—Severe Burns
- Diseases of the Musculoskeletal System and Connective Tissue—Systemic Lupus Erythematosus
- Congenital Anomalies that are complex/chronic--Leg anomaly causing shortening of one leg
- Perinatal Morbidity and Mortality—Extreme Prematurity
- Accidents, Poisonings, Violence, and Immunization Reactions—Trauma leading to severe spinal cord injury

## Special Programs

Several CCS programs are mandated for special segments of the county population and are described below. These are funded separately from the general CCS Program and have different policies and procedures to determine eligibility. The special therapy program usually operates within the public-school context to provide long-term physical and occupational therapy.

## CCS Application Form

Referrals to CCS must include medical documentation from the PCP or specialist. The referring Provider/Practitioner should also provide a CCS Application Form to the parent or guardian of a potentially eligible child and assist in the completion of the forms, if required. MHC Pediatric Case Managers are also available to assist with the application process, if requested. If a family eligible for Medi-Cal the family does not complete the CCS referral, the MHC Pediatric Case Manager, in conjunction with the Pediatric Medical Director, will work with the PCP to develop a comprehensive case management plan to determine the CCS basic services the child can receive, and work to see what other community services might be available.

## Acceptance into CCS Program

If the Member is accepted into the CCS Program, the referring Provider/Practitioner and the member's family receives a Notice of Action from the CCS Program.

## Overview of Referral Process

Initial referrals of Members with CCS eligible conditions may be made to the local CCS program by telephone, same-day mail or fax, if available. The NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR) form (DHCS 4488 (09/15)) shall be filled out completely and accurately, following the instructions included. The submission shall include supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.

## Inpatient Referrals

Hospitals are responsible for making referrals for patients with CCS-eligible conditions admitted to their institutions. Hospitals should fax a copy of the admission History and Physical with referral and Discharge Summary as soon as available even if the admission was prior authorized. CCS must be notified by the next working day following the admission date. The same timeliness rules apply to requests for extending a previously authorized length of stay. Justification of continued hospitalization must accompany extension requests. A list of CCS Approved Hospitals can be found on the DHCS website at: http://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx.

## Authorizations

After CCS eligibility is confirmed, the patient may be directed to an appropriate CCS approved CCS paneled Provider/Practitioner(s). Authorizations are sent by the CCS Program to Providers/Practitioners. CCS reimburses only CCS-paneled providers and CCS-approved hospitals within MHC's network, except in rare, case-by-case instances. All authorizations are for care related to the CCS eligible condition only. MHC remains responsible for covering any hospital stays for non-CCS-eligible conditions.

Authorization for payment shall be retroactive to the date the CCS program was informed about the Member through an initial referral by MHC or a contracted Provider.

In an emergency admission, MHC or Contracted network physician shall be allowed until the next business day to inform the CCS program about the potentially eligible Member. Authorization shall be issued upon confirmation of panel status or determined to meet the CCS standards for paneling.

### PCP Monitoring Process

Once eligibility for the CCS program is established for a Member, the PCP continues to provide Basic Case Management, and all Medically Necessary Covered Services, including Initial Health Assessment (IHA), and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services that are unrelated to the CCS eligible condition. If the local CCS program does not approve eligibility, the PCP remains responsible for the provision of Basic Case Management and all medically necessary diagnostic, preventive and specialty referrals for treatment services, including Initial Health Assessment (IHA), and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Molina audits PCP compliance with these requirements through regularly requesting attestations of compliance, and by performing monthly PCP file audits.

## Early Start Program

The California Early Intervention Services Act, known as Early Start, is designed for children with developmental delays and disabilities or those at high-risk for developmental disabilities who are under three years of age.

Infants and toddlers from birth to age 36 months may be eligible for early intervention services through Early Start if, through documented evaluation and assessment, they meet one of the criteria listed below:

- Have a developmental delay of at least 33 percent in one or more areas of either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing; or
- Have an established risk condition of known etiology, with a high probability of resulting in delayed development; or
- Are considered at high risk of having a substantial developmental disability due to a combination of biomedical risk factors of which are diagnosed by qualified personnel California Government Code: Section 95014(a); California Code of Regulations: Title 17, Chapter 2, Section 52022

The goal of the Early Start Program is to promote and facilitate early identification and access to service delivery for eligible infants and their families. Regional Centers (RCs) and Local Education Agencies (LEAs) are designated as the local agencies to receive referrals, evaluate eligibility, conduct assessments for special needs, prepare an Individualized Family Service Plan (IFSP), and manage coordination of delivery.

## Identification of Condition

PCPs shall refer members to the Early Start Program at the local Regional Center for local resources which may include parent support groups; health care providers with knowledge about early intervention and disabilities; special education, early intervention and preschool programs; regional center contacts and vendor services; advocacy organizations; and other related resources for infants and toddlers with special needs and their families.

The MHC PCP shall coordinate all medical services rendered to an eligible Member.

The PCP or the Member's family may make a referral to the Regional Center (RC) located nearest the Member's place of residence. The MHC Pediatric Case management staff will assist with the referral process as requested by the PCP or Member's family.

The PCP shall complete an intake and assessment for Member's age birth-36 months with, or suspected to have a developmental disability:

- Children shall receive a complete medical evaluation to confirm the diagnosis and determine the genetic and/or non-genetic etiology. This may include, but not be limited to:
  - Prenatal/perinatal history
  - Developmental history
  - Family history
  - Metabolic and chromosomal studies
  - Specialty consultations as indicated
- Regional Center Prevention Program - Medical Factors, Guidelines
  - Prematurity <32 weeks gestation or low birth weight <1,500 grams
  - Small for gestational age, below the 3rd percentile
  - Severe respiratory distress requiring assisted ventilation for >48 hours during the first 28 days of life
  - Asphyxia neonatorum associated with APGAR scores five minutes apart of three or less
  - Hyperbilirubinemia requiring exchange transfusion
  - Severe and persistent metabolic abnormality
  - Neonatal seizures or nonfebrile seizures during the first three years of life
  - Central nervous system lesion or abnormality
  - Central nervous system infection
  - Serious biomedical insult which may affect developmental outcome
  - Multiple congenital anomalies or genetic disorders which may affect developmental outcome
  - Prenatal exposure to know teratogens
  - Positive neonatal toxicology screen or symptomatic neonatal drug withdrawal
  - Clinically significant failure to thrive
  - Being an infant of a developmentally disabled parent may also be considered a risk factor

- Referrals shall be directed to the intake screener of the Regional Center. Note: When referring to both CCS and RC, one referral shall not delay the other. The PCP may notify CCS and the Regional Center simultaneously if both the medical and early intervention services are necessary. The PCP shall route member information to the RC as soon as possible. Information shall include the following:
  - Reason for referral
  - Complete medical history and physical examination, including appropriate developmental screens
  - The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated

Anyone can make a referral to the RC, including parents, medical care providers, neighbors, family members, foster parents, and day care providers.

The PCP is responsible for notifying parents/guardians for the availability of Early Start Services.

The PCP is to cooperate and collaborate in the development of the Individual Program Plan (IPP).

### Referral Coordination with California Children Services

In situations where the Member is eligible for both CCS and Early Start, the first or primary referral should be to CCS, if the diagnosis or treatment for the CCS eligible condition is the major concern. The PCP should notify CCS and the appropriate RC simultaneously when both medical and early intervention services are necessary.

### Coordination of Care

Depending on plan affiliation, the Pediatric Medical Case Manager and Pediatric Medical Director are available to assist PCPs and families with the referral procedure to ensure their referral was completed successfully and services were activated. If a Member was previously referred to or accepted into the Early Start Program, the Pediatric Medical Case Manager assesses the case to determine if further case management services, including health education, are needed. The Pediatric Medical Case Manager also contacts the parent/guardian for approval to discuss the member's care with a RC service consultant.

Once the referral has been made, the PCP and Pediatric Medical Case Manager will:

- Provide/refer for medically necessary therapy and/or equipment
- Continue with medical management
- Consult with and provide appropriate reports to the Early Intervention Team
- Assist the client and/or family in following the IFSP recommendation

MHC will provide transportation to these appointments. Assistance with arrangement for transportation is available through the health plan contracted vendor American Logistics (844) 292-2688.

### Consent, Record Keeping, and Confidentiality

The Member or parent/guardian of a minor is asked to consent to any screening, assessment, or treatment. Results of any screening, assessment, or treatment will be recorded in the Member's medical record.

- Documentation will be in compliance with MHC Policy and Procedure, regarding Collection/Use/Confidentiality and Release of Primary Health Care Information
- Findings, recommendations, and response to recommendations will be recorded by the Provider/Practitioner in the Member's medical record
- All information and results of the health assessment of each Member will be confidential and will not be released without the informed consent of the Member or parent/guardian
- Appropriate governmental agencies will have access to records without consent of the Member or responsible adult, i.e., DHCS, DMHC, etc.

## Developmental Disability Service and Regional Center Coordination

The California Department of Developmental Services (DDS) is responsible for a system of diagnosis, counseling, case management, and community support of persons with intellectual disability, cerebral palsy, epilepsy, autism and related conditions. These services are provided through state-operated developmental centers and community facilities, and contracts with 21 nonprofit Regional Centers (RC). The regional centers serve as a local resource to help find and access the services and supports available to individuals with developmental disabilities and their families.

RCs are private, non-profit corporations under contract with the DDS. Their purpose is to enable people with developmental disabilities to lead as independent and productive lives as possible, to protect the legal rights of people with developmental disabilities and their families, and to reduce the incidents of developmental disabilities. Providers/Practitioners must provide eligible Medi-Cal members identified with, or suspected of having, developmental disabilities with all medically necessary and appropriate developmental screenings, primary preventive care, and diagnostic and treatment services. For members at risk of parenting a child with a developmental disability, MHC provides genetic counseling and other prenatal genetic services.

DDS services are for eligible members from 36 months to adults. DDS covers Members with a disability that originates before the member attains 18 years of age, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap for such individual. This may include mental intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to intellectual disability or requiring treatment similar to that required for intellectually disabled individuals, including genetic screening and counseling when indicated. DDS does not include other disabling conditions that are (1) Solely Psychiatric Disorders; (2) Solely Learning Disabilities; and (3) Solely physical in nature.

## Eligibility Determination

The Primary Care Physician (PCP) shall provide developmentally disabled Members with all appropriate screening, preventive, Medically Necessary, and therapeutic Covered Services. Preventive care will be provided according to the most recent American Academy of Pediatrics Guidelines for children, the Guidelines of United States Preventive Services Task Force for adults and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services. EPSDT benefit provides comprehensive screening, diagnostic, treatment and preventive health care services.

The PCP shall assess and refer eligible Members with developmental disabilities to the Regional Centers for those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of- home placement and supportive living.

The MHC PCP shall coordinate all medical services rendered to eligible Members.

The PCP shall complete an intake and assessment for members aged 36 months to 18 years old with, or suspected to have a developmental disability:

- Members shall receive a complete medical evaluation to confirm the diagnosis and determine the genetic and/or non-genetic etiology. This may include, but not be limited to:
  - Prenatal/perinatal history
  - Developmental history
  - Family history
  - Metabolic and chromosomal studies
  - Specialty consultations as indicated

## Referral Process

The PCP may refer members who are in need of non-medical, home and community-based services to the RC such as but not limited to:

- Respite
- Out-of-home Placement
- Supported Living & Related Services

Members having, or suspected of having, a developmental disability may be referred to the RC nearest the Member's place of residence. Referrals from the PCP should be directed to the Intake Coordinator at the RC and will include the reason for referral, the complete medical history and physical examination report with appropriate developmental screens, the results of developmental assessment/psychological evaluation, and other diagnostic tests as indicated. California Regional Centers Directory may be accessed at: http://www.dds.ca.gov/rc/RCList.cfm.

When MHC and the Pediatric Medical Director determine that a Member between the ages of 36 months and 18 years of age is potentially eligible for a RC service, the

Pediatric Case Manager will contact the PCP or specialist to determine if the Member and the family have been informed and have approved the referral or have been previously referred or accepted into a RC.

If a Member was previously referred to or accepted into the RC, the Pediatric Case Manager assesses each individual case to determine if further case management services are needed. If services are not required, MHC contacts the parent/guardian for approval to discuss the Member's case with the RC. If the Member was not previously referred to or accepted into the RC, the Pediatric Case Manager contacts the PCP and the family regarding assistance with the referral process. If requested, the Pediatric Case Manager assists the family and Provider/Practitioner to complete the referral process.

### Intake and Assessment

RCs shall review referrals to determine RC eligibility and consider the need for development programs or family support services which are not available from other generic or private sources

The PCP shall be directed to the RC's intake coordinator and shall provide the following information:

- Reason for referral
  - Complete medical history and physical examination, including appropriate developmental screens
  - The results of developmental assessment/psychological evaluation and other diagnostic tests as indicated

The RC shall review the referral within 15 working days of receipt.

### Primary Care Practitioner's Responsibilities

PCP shall perform developmental screening including vision and hearing assessments and review of dental status at intervals specified in the CHDP/EPSDT policies and procedures for children up to age 18.

Medically necessary diagnostic and treatment services for physical and developmental conditions identified in the screenings shall be provided or arranged.

- Primary care and specialized medical treatment necessary shall be provided for:
  - All Medically Necessary and therapeutic Covered Services to Members with developmental disabilities
- The PCP shall assure evaluation and procurement of the durable and non-durable medical equipment according to UM guidelines

### Referral Coordination with California Children Services

In situations where the child is eligible for both California Children Services (CCS) and RC services, the first referral should be to CCS if diagnosis or treatment for CCS eligible

conditions is the major concern. The Provider/Practitioner may wish to notify CCS and the appropriate RC simultaneously if both medical and early intervention services are necessary.

## Regional Center Responsibilities

The Department of Developmental Services is responsible for designing and coordinating a wide array of services for California residents with developmental disabilities. Regional centers help plan, access, coordinate and monitor these services and supports.

A Person-Centered Planning approach is used in making decisions regarding where a person with developmental disabilities will live and the kinds of services and supports that may be needed. In person-centered planning, everyone who uses Regional Center services has a planning team that includes the person utilizing the services, family members, Regional Center staff and anyone else who is asked to be there by the individual. The team joins together to make sure that the services that people are getting are supporting their choices in where they want to live, how and with whom they choose to spend the day and hopes and dreams for the future.

## Case Management

- When accepted by the Member's parent, MHC will provide coordination of care and services with primary care practitioners, specialists, and allied health professionals (including speech, occupation and physical therapists), procuring of durable and non-durable medical equipment and securing in-home nursing services and EPSDT supplemental services.
- When needed medical sub-specialty services are not available within the network, the service will be provided out-of-network, with the continuity of care maintained.
- With the written consent of the member or parent/guardian of a minor, medical records will be routed to the RC when appropriate.
- Pediatric Case Management will provide follow-up and coordination of the treatment plan between the MHC PCP, any specialists, and the RC.

Case Management includes the following:

- For Members 36 months to age 21 years old, providing or arranging for medically necessary diagnostic and treatment services necessary to correct and/or ameliorate conditions discovered in the screening process.
- Providing available medical documentation and reports, as requested, to the Pediatric/RC Case Manager.
- Providing or arranging for medically necessary therapies and durable medical equipment.

## Transportation

MHC will provide transportation to these appointments. Assistance with arrangement for transportation is available through the health plan contracted vendor, American Logistics (844) 292-2688.

## Unresolved Questions and Conflicts

RC staff determines eligibility and provides case management services to their clients. Issues that arise between the RC and MHC, or the PCP will be resolved by MHC's Pediatric Medical Director or the Medical Director of the affiliated health plan. During any problematic periods, a Pediatric/RC Case Manager and the PCP or specialty practitioner will continue to manage the medical case of the Member. Pediatric/RC Medical Case Managers will maintain routine interaction with the RC and will share data regarding health care encounters and program enrollment figures.

Unresolved questions and conflicts between MHC and RC concerning eligibility, diagnostic testing, treatment plan, and associated Member benefits, should be directed to either of the following:

Molina Healthcare of California
Attn: Health Care Services Regional Center Liaison

Manager, DDS Prevention and Children Services Branch
Department of Developmental Services
PO Box 944202
Sacramento, CA 94244-2020
(916) 654-1690 or TYY: (916) 654-2054

The MHC Pediatric/RC Case Manager and Pediatric Medical Director will coordinate and authorize all immediate health care needs for the Member in collaboration with the PCP until resolution is obtained.

## PCP Monitoring Process

Once eligibility for a RC program is established for a member, the PCP continues to provide Basic Case Management, and all Medically Necessary Covered Services, including Initial Health Assessment (IHA), and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings that are unrelated to the RC eligible condition. The PCP remains responsible for the provision of Basic Case Management and all medically necessary diagnostic, preventive and specialty referrals for treatment services, including Initial Health Assessment (IHA), and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings. Molina audits PCP compliance with these requirements through regularly requesting attestations of compliance, and by performing monthly PCP file audits.

## Regional Centers—More Information

The DDS contracts with the RCs to offer services in all 58 California counties. Located throughout the State, the local RCs serve as the point of entry into the developmental mental disabilities service system. i The RCs provide intake and assessment services to determine client eligibility and service needs. RCs then work with other agencies and utilize “generic services” whenever possible to arrange purchase and provide services including the full range of early intervention services. Early intervention services that cannot be provided by other publicly funded agencies are generally purchased through contracts with service Providers/Practitioners that are “vendored” by a RC. Services vary among the RCs based on local needs and resources.

Included for reference is the RC’s Information Sheet and Roster below.

| REGIONAL CENTERS | DIRECTOR | AREAS SERVED |
|---|---|---|
| **Alta California**<br>2241 Harvard St., Ste. 100<br>Sacramento, CA 95815 | (916) 978-6400 | Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba counties |
| **Central Valley**<br>4615 North Marty Ave.<br>Fresno, CA 93722 | (559) 276-4480 | Fresno, Kings, Madera, Mariposa, Merced, and Tulare counties |
| **Eastern Los Angeles**<br>1000 South Fremont, #23<br>Alhambra, CA 91802<br><br>**Mailing Address:**<br>P.O. Box 7916<br>Alhambra, CA 91802 | (626) 299-4700 | Eastern Los Angeles county including the communities of Alhambra and Whittier |
| **Far Northern**<br>1377 E Lassen Ave<br>Chico, CA 95973 | (530) 895-8633 or<br>(530)222-4791 | Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama, and Trinity counties |
| **Frank D. Lanterman**<br>3303 Wilshire Blvd., Ste. 700<br>Los Angeles, CA 90010 | (800) 546-3676 | Central Los Angeles county including Burbank, Glendale, and Pasadena |
| **Golden Gate**<br>1355 Market Street, Suite 220<br>San Francisco, CA 94103 | (415) 546-9222 | Marin, San Francisco, and San Mateo counties |
| **Harbor**<br>21231 Hawthorne Blvd.<br>Torrance, CA 90503 | (310) 540-1711 | Southern Los Angeles county including Bellflower, Harbor, Long Beach, and Torrance |
| **Inland - San Bernardino**<br>1365 S. Waterman Ave. San Bernardino, CA 92408<br><br>**Inland – Riverside**<br>1500 Iowa Ave., #100<br>Riverside, CA 92507 | (909) 890-3000<br><br>(951) 826-2600 | Riverside and San Bernardino counties |

| REGIONAL CENTERS | DIRECTOR | AREAS SERVED |
|---|---|---|
| **Kern**<br>3200 North Sillect Ave.<br>Bakersfield, CA 93308 | (661) 327-8531 | Inyo, Kern, and Mono counties |
| **North Bay**<br>610 Airpark Road<br>Napa, CA 94558 | (707) 256-1100 | Napa, Solano, and Sonoma counties |
| **North LA County**<br>9200 Oakdale Ave, Ste 100<br>Chatsworth, CA 91311 | (818) 778-1900 | Northern Los Angeles county including San Fernando and Antelope Valleys |
| **Redwood Coast**<br>525 Second St. Suite 300<br>Eureka, CA 95501 | (707) 445-0893 | Del Norte, Humboldt, Mendocino, and Lake counties |
| **San Andreas**<br>6203 San Ignacio Ave, Ste.200<br>San Jose, CA 95119 | (408) 374-9960 | Monterey, San Benito, Santa Clara, and Santa Cruz counties |
| **San Diego**<br>4355 Ruffin Rd., Ste. 200<br>San Diego, CA 92123 | (858) 576-2996 | Imperial and San Diego counties |
| **San Gabriel/Pomona**<br>75 Rancho Camino Drive<br>Pomona, CA 91766 | (909) 620-7722 | Eastern Los Angeles county including El Monte, Monrovia, Pomona, and Glendora |
| **South Central LA**<br>2500 S. Western Ave.<br>Los Angeles, CA 90018 | (213) 744-7000 | Southern Los Angeles county including the communities of Compton and Gardena |
| **Tri-Counties**<br>520 East Montecito St.<br>Santa Barbara, CA 93103 | (805) 962-7881 | San Luis Obispo, Santa Barbara, and Ventura counties |
| **Valley Mountain**<br>702 North Aurora St.<br>Stockton, CA 95202<br><br>**Mailing Address:**<br>PO Box 692290<br>Stockton, CA 95269-2290 | (209) 473-0951 | Amador, Calaveras, San Joaquin, Stanislaus, and Tuolumne counties |
| **Westside**<br>5901 Green Valley<br>Cir. Ste. 320<br>Culver City, CA 90230-6953 | (310) 258-4000 | Western Los Angeles county including the communities of Culver City, Inglewood, and Santa Monica |

# 14. HEALTHCARE SERVICES: WAIVER PROGRAMS

## Developmental Disabilities Services Waiver

The Developmental Disabilities Services (DDS) administered Home and Community Based Services (HCBS) waiver program was established to meet the medical needs of developmentally disabled Medi-Cal recipients aged 36 months to adults. DDS includes members with a disability that originates before the Member attains 18 years of age, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap for such individual. DDS and MHC coordinate the medical management of chronically ill, developmentally disabled Medi-Cal Members, including those with catastrophic illnesses, technologically dependent and/or risk of life-threatening incidences, who, but for the provision of such services, would reside in an intermediate care facility for the developmentally disabled.

### DDS HCBS Waiver Program

Regional Centers (RCs) oversee the DDS administered HCBS waiver program. There are four types of care settings in the HCBS waiver program:

- Member's home where specialized services may be delivered
- Local intermediate care facility licensed as an ICS/DD
- Local habilitative developmental-disability care facility licensed as a DDH
- Local nursing developmental-care facility licensed as a DDN

The RC Inter-Disciplinary Team is responsible for determining the HCBS waiver setting most appropriate for the eligible Member. Although the RCs provide overall case management, they are not responsible for the direct medical services. During the Member's participation in the DDS administered waiver program, MHC will continue to provide all primary care and other medically necessary services.

### Eligibility

MHC Case Management staff will monitor and review inpatient stays of members with a potential need for supportive care, to determine appropriate utilization and to identify Members who may potentially benefit from a DDS HCBS waiver. Case Managers will also work to ensure that potentially eligible Members are referred in a timely manner. Included for your reference is the DHCS assigned waiver criteria.

### Referrals to HCBS

When a Case Manager is notified of a Member with a potential need for supportive care, the Case Manager will initiate a request for the medical record from the Member's Primary Care Practitioner (PCP). Upon receipt of the Member's medical records, the Case Manager and the Medical Director will review the records to determine if there is a need for supportive care. If supportive care is not needed, no referral is made, and the Member or family is notified.

If supportive care is deemed necessary, a case conference will be conducted with the Member and/or family, PCP, specialist, ancillary Providers/Practitioners, and MHC Case Manager. The MHC Case Manager is responsible for coordinating with the RC Case Manager and the PCP.

## Referral and Coordination of Services

Once a Member is deemed eligible for the DDS administered HCBS program, a RC Case Manager is assigned to coordinate waiver services. The receiving of DDS administered HCBS services does not warrant or require a Member's disenrollment from the Plan.

## PCP's Responsibilities

The PCP's primary responsibility is to refer Members, transmit medical records, and develop a plan of treatment. The PCP, along with the Case Manager as necessary, is still required to provide and coordinate care.

The Case Manager is responsible for coordinating with the RC Case Manager and the PCP in the development of the Member's individual services plan/individual education plan.

If the Member is receiving services through DDS, the Case Manager assists in coordinating care with the PCP and RC. If the Member is not receiving services through DDS, the Case Manager conducts an analysis of the cost-effectiveness of in-home services versus institutional services:

- If the member's condition meets criteria for the waiver program, the Case Manager makes an appropriate referral to DDS at:

  Department of Developmental Services
  Department of Health Care Services
  1600 9th Street
  P.O. Box 944202
  Sacramento, CA 94244-2020
  (916) 654-1690

- If the member does not meet the criteria for the waiver program, or if placement is not available, MHC will continue to case manage and provide all medically necessary services to the member

## Problem Resolution

RC's staff determines eligibility and is responsible for the overall case management of the member. In the event that MHC is in disagreement with the RC's decision and/or recommendation concerning the provision of waiver services, the Case Manager will be responsible for problem resolution. The Case Manager will continue to coordinate and

authorize all immediate health care needs for the member in collaboration with the PCP until resolution is reached.

## Waiver Programs – Developmental Disabilities

### DDS HCBS Waiver Participants

Administered by the Department of Developmental Services:

- A recipient may only receive waiver services from the DDS HCBS
- A recipient may receive Medi-Cal benefits if "medically necessary"
- A recipient may receive Supplemental EPSDT benefits up to age 21
- A recipient of waiver services must meet the criteria for participation in the waiver program AND meet the criteria for medical necessity
- The determinations of eligibility for participation in the DDS HCBS waiver are made by the RC
- The determinations of necessity of services are made by the RC Interdisciplinary Team using their person- centered planning process
- If the member has a qualifying condition or diagnosis under the Developmental Disabilities Program for the Waiver Programs and the Member is over age 21, the MHC Case Management Department will evaluate eligibility for other programs
- Children with diagnosis of developmental delay are not eligible for the DDS HCBS waiver
- Children at risk of developing a developmental disability are not eligible for the DDS HCBS waiver
- The Member must be a consumer of the RC and the RC will be contacted to provide oversight
- The Member must meet the admission requirements for an ICF/DD, ICF/DD-H, or ICF/DD-N facility and require some medical care and active treatment
- The Member must be a Medi-Cal beneficiary

### Institutional DDS HCBS Waiver Participants

- The Member must meet all criteria for DDS HCBS waiver program
- The Member must have been determined eligible for DDS HCBS waiver services
- The Member must receive a referral from the RC to the County for Medi-Cal fiscal eligibility determination using institutional rules
- The Member must receive at least one DDS HCBS waiver service at all times in order to maintain Medi- Cal eligibility

## AIDS Waiver Program

The AIDS Waiver Program is designated to provide in-home care to recipients who would otherwise require institutionalization in a medical facility for a prolonged period.

## Eligibility

To qualify for enrollment in the AIDS Waiver Program, members with Acquired Immune Deficiency Syndrome (AIDS) or symptomatic Human Immunodeficiency Virus (HIV) disease must meet the following criteria:

- Be Medi-Cal eligible
- Require nursing facility (NF) level of care or above
- Score 60 or less on the Kamofsky Scale
- Have exhausted other coverage for health care benefits similar to those available under the AIDS waiver prior to utilization of AIDS waiver services
- Have a safe home setting

For children, waiver agencies must choose the Centers for Disease Control and Prevention "Classification System for Human Immunodeficiency Virus Infection in Children under 13 Years of Age." Children must be classified as "P2" under the CVC classification to be eligible for the waiver program.

The PCP, with assistance from the Case Management staff, as requested, will inform eligible members about the availability of the AIDS Waiver Program. At the request of a member, the PCP will provide the Waiver Agency with appropriate medical documentation including:

- History and physical
- Relevant lab results
- Therapeutic regime

Information and documentation will be submitted for acceptance to:

Office of AIDS, California Department of Public Health (CDPH)
MS7700
P.O. Box 997426
Sacramento, CA 95899-7426

(916) 449-5900
(916) 449-5909

## Case Management and Coordination Process

Once MHC Case Management Staff is notified of a Member with a potential need for supportive care, staff requests medical records from the Member's PCP. Case Management Staff, with the PCP, meets with the Member and caregivers to discuss AIDS Waiver Program availability:

- If the Member is eligible for and requests program referral, the type of supportive care needed is identified and a referral is initiated by the Case Manager
- If the Member is determined to be ineligible or declines program referral, the Case Manager initiates case management as necessary

The Case Manager coordinates the transfer of the case management plan and/or any pertinent information to the AIDS Waiver Program representative. Financial limitations of the program are provided on a yearly basis per patient per calendar year. The carve-out of AIDS medications is included for your reference.

### Problem Resolution

Resolution of problems or conflicts between the HIV/AIDS provider/practitioner and Office of AIDS can be addressed to either of the following:

Molina Healthcare of California
Attn: Chief Medical Officer
200 Oceangate, Suite 100
Long Beach, CA 90802

(800) 526-8196

Office of AIDS
California Department of Public Health
MS7700
P.O. Box 997426
Sacramento, CA 95899-7426

Tele: (916) 449-5900
Fax: (916) 449-5909

## Home and Community-Based Services

The Home and Community Based Services (HCBS) are designated to provide in-home care to recipients who would otherwise require institutionalization in a medical facility for a prolonged period.

The medical management of chronically ill Members, including Members with catastrophic illnesses, technologically dependent and/or risk of life-threatening incidences; require close coordination between MHC, its subcontracted Providers/Practitioners, and the HCBS waiver program. The primary goal is to ensure that the medical needs of Members who are physically, and possibly mentally, disabled are met appropriately and safely in a home environment.

- Home and Community-Based Alternatives (HCBA) Waiver - The HCBA Waiver is designed to provide care management services to persons at risk for nursing home or institutional placement. The care management services are provided by a multidisciplinary care team comprised of a nurse and social worker. The care management team coordinates Waiver and State Plan services (e.g., medical, behavioral health, In- Home Supportive Services, etc.), and arranges for other available long-term services and supports available in the local community. Care management and Waiver services are provided in the Participant's community-

based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a Participant's family member
- Assisted Living Waiver (ALW) - The ALW facilitates a safe and timely transition of Medi-Cal eligible seniors and persons with disabilities from a nursing facility to a community home-like setting in a Residential Care Facility for the Elderly (RCFE), an Assisted Living Facility (ALF), or public subsidized housing, utilizing ALW services; and offers eligible seniors and persons with disabilities, who reside in the community, but are at risk of being institutionalized, the option of utilizing ALW services to develop a program that will safely meet his/her care needs while continuing to reside in a RCFE, ALF, or public subsidized housing

### Case Management and Coordination Process

Once MHC Case Management Staff is notified of a Member with a potential need for supportive care, staff requests medical records from the Member's PCP. Case Management Staff, with the PCP, meets with the Member and caregivers to discuss waiver program availability:

- If the Member is eligible for and requests program referral, a referral is initiated by the Case Manager
- If the Member is determined to be ineligible or declines program referral, the Case Manager initiates case management as necessary

### Referral Process

Referrals for the HCBS waivers are made to the appropriate agency contracted with the state to provide the services. The agency will submit the completed application to DHCS. HCBA and ALW applicants who potentially meet the waiver level of care criteria are placed on a waitlist as both waivers have limited slots. DHCS will determine eligibility for both waivers.

### Eligibility for Home and Community-Based Alternatives (HCBA) Waiver Program

- The beneficiary for whom HCBA waiver services are requested would otherwise require care in a nursing home
- The total cost incurred by the Medi-Cal program in providing HCBA waiver services and other medically necessary Medi-Cal services to the beneficiary is less than the total cost incurred by the Medi-Cal program in providing all medically necessary services to the beneficiary in a nursing home
- The individual has been in an institutional setting for at least 90 days and will remain there if not for the provision of HCBA Waiver services in the home or community setting; or
- The individual must be a current Medi-Cal member who will turn 21 years of age during the current calendar year and has been receiving, or has been authorized to receive, private duty nursing services for at least 6 months prior to his/her 21st birthday; or

- The patient is residing in the community and is at a high risk of institutionalization
- Members do not need to disenroll from MHC while they are enrolled in the HCBA waiver

# 15. HEALTHCARE SERVICES: LONG TERM SERVICES AND SUPPORTS

Molina Medi-Cal Members have access to a variety of Long-Term Services and Supports (LTSS) to help them meet daily needs for assistance and improve quality of life. LTSS benefits are provided over an extended period, mainly in Member homes and communities, but also in facility-based settings such as nursing facilities as specified in his/her Individualized Care Plan. Overall, Molina's care team model promotes improved utilization of home and community-based services to avoid hospitalization and nursing facility care.

LTSS includes all of the following:

- Community Based Adult Services (CBAS)
- In Home Supportive Services (IHSS)
- Multipurpose Senior Services Program (MSSP)
- Long Term Care, Custodial Level of Care in a Nursing Facility

Under the California Coordinated Care Initiative (CCI) which began in April 2014 for Riverside, San Bernardino and San Diego counties and in July 2014 for Los Angeles county, beneficiaries who wish to receive these services must get them through a Medi-Cal Managed Care Plan. Molina Members in Sacramento and Imperial counties will also get CBAS through Molina, but the other LTSS options remain as waiver programs. Under California policy Molina provides coordination between medical care, LTSS, and mental health and substance use benefits covered by Medicare and Medi-Cal. Much of this coordination requires stronger partnership between Molina and county agencies that provide certain LTSS benefits and services. The MOU between Molina and county agencies delineates roles and responsibilities, and processes for referrals and will serve as the foundation for such coordination efforts.

## Multipurpose Senior Services Program

Multipurpose Senior Services Program (MSSP) provides social and health care management for frail elders who are eligible for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care.

MSSP assists frail, elderly members, sixty-five (65) years and over and at-risk of nursing home placement, to remain safely in their homes. MHC members may be eligible for MSSP if they are sixty-five (65) years of age or older, live within an MSSP sites service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP site staff makes this certification determination based upon Medi-Cal criteria for placement.

MSSP services include:

- Care management
- Adult day care
- Minor home repair/maintenance
- Supplemental in-home chore, personal care, and protective supervision services
- Respite services
- Transportation services
- Counseling and therapeutic services
- Meal services
- Communications services

### Referral and Coordination Process

MHC Case Management staff monitors and reviews members to determine appropriate utilization of services and to identify Members who may potentially benefit from the MSSP program.

Providers needing to make a referral should call our Case Management department at FAX: (562) 499-6105 PHONE: (844) 203-4287 and follow the prompts or MHCCaseManagement@MolinaHealthcare.com and request assistance in referring the Member for MSSP and other community resources.

MHC Case Management staff will make referrals as appropriate and work along with the PCP to work with the MSSP Waiver Case Management Team to coordinate appropriate services.

### Case Management Process

If the Member is determined to be eligible for program referral to the MSSP, MHC or affiliated subcontracted plan Case Manager shall participate in the MSSP Case Management Team, as applicable, to develop a comprehensive case management plan. The Case Manager may assist the MSSP team to ensure timely, effective, and efficiently coordinated services to meet the Member's care plan goals.

### Problems and Resolutions

In the event that there is a disagreement with the MSSP decision and/or recommendations concerning the provision of waiver services, please refer to the State APL 15-002 Multipurpose Senior Services Program Complaint, Grievance, Appeal, and State Hearing Responsibilities in Coordinated Care Initiative Counties.

## Community Based Adult Services (CBAS)

Licensed Community Based Adult Services (CBAS) Centers provide health and social services as an alternative to institutionalization and a safe and therapeutic environment for adult MHC Members with eligible conditions.

As of October 1, 2012, MHC became financially responsible for all CBAS services; however, the Primary Care Practitioner (PCP) continues to be responsible for providing medically necessary care. CBAS includes nursing and therapeutic care for the Member who may have a physical or mental impairment that handicaps daily activities but who does not require institutionalization.

### Eligibility

To be eligible to receive CBAS services, one of the following criteria's must be met:

- Nursing facility level of care A eligible
- Organic, acquired or traumatic brain injury or chronic mental health
- Alzheimer's disease or other dementia stage 5, 6, 7
- Mild cognitive impairment, including Moderate Alzheimer's stage 4
- Developmental disability
- A physician, nurse practitioner or other health care provider has within his/her scope of practice requested ADHC services
- Member must need assistance or supervision with two or more of the following activities of daily living: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, hygiene or one previously listed ADL and one of the following activities of daily living: money management, accessing resources, meal preparation or transportation

### Referral

- Complete & fax CBAS Request for Services Form at: (800) 811-4804
- For more information or if you have any questions, please call MHC Utilization Management Department at: (844) 557-8434 or Member Services Department at (888) 665-4621

## In-Home Supportive Services

In-Home Supportive Services (IHSS) is a California program that provides in-home care for Members who cannot safely remain in their own homes without assistance. To qualify for IHSS, Members must be 65 years of age or over, or disabled, or blind By providing in-home assistance to low income aged and disabled individuals, the IHSS program prevents premature nursing home or board and care placement and allows people to remain safely in their own homes and communities.

IHSS is covered under the Medi-Cal benefit. Molina Healthcare of California coordinates IHSS benefits for eligible enrollees through county IHSS agencies. IHSS consumers' self-direct their care by hiring, firing, and managing their IHSS workers. County social services agencies conduct the IHSS assessment and authorization processes, including determining IHSS hours. The current fair hearing process for IHSS remains the same.

Services included in IHSS include:

- Housecleaning
- Meal preparation and clean-up
- Laundry
- Grocery shopping and errands
- Personal care services (bowel/bladder care, bathing, grooming, dressing and feeding, etc.)
- Paramedical services (help with injections, wound care, colostomy, and catheter care, etc.)
- Accompaniment to medical appointments
- Protective supervision for persons with cognitive or intellectual disabilities

One of the most noteworthy aspects of the IHSS program is the beneficiaries' ability to self-direct their care. Self-directed care is the process by which the IHSS consumer chooses to hire, train, supervise, and if necessary, fire their personal assistant. In situations where the member is unable to self-direct their care, Molina case managers will coordinate with county social workers.

### How to Refer Molina Members in Need of IHSS Services

Providers needing to make a referral should call Member Services at (888) 665-4621 or the Case Management department at (844) 203-4287 or email MHCCaseManagement@MolinaHealthcare.com and request assistance in referring the member for IHSS and other community resources.

Members can also call or visit their local County Social Services agency to verify eligibility and begin the application process. The Health Certification Form will be sent to the member by the county social worker. It is important to note that the application process cannot continue until the physician has completed it.

- Sacramento County Dept. of Human Assistance: (916) 874-9471
- San Diego County Dept. of Health & Human Services: (800) 339-4661
- Riverside County Dept. of Public Social Services: (888) 960-4477
- San Bernardino County Dept. of Human Services: (877) 800-4544
- Los Angeles County Dept. of Public Social Services: (888) 944-4477
- Imperial County Dept. of Social Services: (760) 337-3084

## Long-Term Care

MHC will ensure that eligible Members, other than Members requesting hospice, in need of nursing facility services are placed in facilities providing the appropriate level of care commensurate with the Member's medical needs.

### Eligibility and Referral

When a referral to a long-term care facility is initiated by an in-patient attending physician, the MHC Medical Director will be notified by MHC Utilization Management

Department. The PCP receives a discharge summary which includes the discharge disposition to a long-term care facility. If a member is assigned to an IPA and gets admitted to a long-term facility, the member gets disenrolled from the IPA and enrolled into Molina direct.

Referral to the appropriate long-term care facility should be made when the Provider/Practitioner has determined that the Member meets, or may meet, the criteria for any of the following long-term care facilities:

- Transitional care
- Intermediate care facility
- Sub-acute care facility
- Rehabilitative care facility
- Pediatrics sub-acute care facility
- Skilled nursing facility (SNF)
- Short-term care
- Long-term care
- Custodial care

Potentially appropriate Members for long-term care referral are identified by MHC's or affiliated health plan's Utilization Management Nurse Reviewers during the admission and concurrent review process.

Other sources of identification include, but are not limited to, case managers, specialty care Providers/Practitioners, social workers, discharge planners, and any other health care Providers/ Practitioners involved in the Member's care.

Long-term care guidelines for determining the appropriate level of care are based on the MC/FFS guidelines.

## Authorization

The PCP will perform an assessment of the Member's needs to determine appropriate level of service prior to the request for an admission to a long-term care facility. The PCP will obtain an authorization for admission to a long-term care facility from MHC's Utilization Management Department. The Utilization Management Department will direct the admission to a contracted long-term care facility. If a contracted facility is unavailable to meet the Member's needs, the Member will be placed at an appropriate facility on a case-by-case basis. The frequency of review by the UM Medical Director will be based on the Member's acuity and clinical condition.

If the Member does not meet the criteria for custodial level of care or an admission to a long-term care facility, Molina will continue to provide case management services until the care plan goals are completed.

For custodial authorization or outpatient services needed while in custodial level of care, please fax all requests to the prior authorization department at (800) 811-4804.

For any questions regarding custodial authorization or services needed while in custodial level of care, please contact the MHC UM Prior Authorization Department at (844) 557-8434.

## Hospice Care

Hospice services are a covered benefit regardless of the expected or actual length of stay in a nursing home. Members with terminal illnesses (a life expectancy of less than six months) are candidates for hospice services. The determination of medical appropriateness for hospice is performed by the PCP or the Provider/Practitioner in charge of the member's care.

Once the determination for hospice is deemed appropriate, the PCP will obtain an authorization from the HCS Department. The Utilization Management Nurse Reviewer will monitor the case and ensure coordination of all necessary services.

# 16. HEALTHCARE SERVICES: ALCOHOL & SUBSTANCE USE DISORDERS TREATMENT & SERVICES

## Alcohol and Drug Treatment Services

Drug Medi-Cal (D/MC), also referred to as Short-Doyle Medi-Cal (SD/MC), alcohol and drug treatment services are excluded from MHC's Medi-Cal Drug and Alcohol coverage responsibility under the Two-Plan Model Contract. Services are available under the SD/MC programs and through Heroin Detoxification Treatment Services. These services are provided through county operated SD/MC programs, or through direct contracting between the State Department of Alcohol and Drug Programs and community-based Providers/Practitioners.

MHC and subcontracted Providers/Practitioners coordinate referrals for Members requiring specialty and inpatient clinical dependency/substance abuse treatment and services. Members receiving services under the SD/MC Program remain enrolled in MHC. Contracted PCPs are responsible for maintaining continuity of care for the Member.

## Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

California offers an Alcohol and Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) benefit to Medi-Cal beneficiaries ages 11 and older, including pregnant women, in primary care setting This benefit may be provided by providers within their scope of practice, including, but not limited to physicians, physician assistants, nurse practitioners, certified and licensed nurse midwives, and licensed behavioral health providers.

In providing SABIRT services, MCPs must comply with all applicable laws and regulations relating to the privacy of SUD records, as well as state law concerning the right of minors over 12 years of age to consent to treatment including, without limitation, Title 42 Code of Federal Regulations (CFR) Section 2.1 et seq., 42 CFR Section 2.14, and Family Code Section 6929.

- Screening: Unhealthy alcohol and drug use screening must be conducted using validated screening tools. Validated screening tools include, but are not limited to:
  - Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
  - Tobacco Alcohol, Prescription medication and other Substances (TAPS)
  - National Institute on Drug Abuse (NIDA) Quick Screen for adults
  - The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening
  - Drug Abuse Screening Test (DAST-10)
  - Alcohol Use Disorders Identification Test (AUDIT-C)
  - Parents, Partner, Past and Present (4 Ps) for pregnant women and adolescents

    - Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
    - Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population
- Brief Assessment: unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:
    - NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
    - Drug Abuse Screening Test (DAST-20)
    - Alcohol Use Disorders Identification Test (AUDIT)
- Brief Interventions and Referral to Treatment: For recipients with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable AUD or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:
    - Providing feedback to the patient regarding screening and assessment results;
    - When a screening is positive, validated assessment tools should be used to determine if;
    - Discussing negative consequences that have occurred and the overall severity of the problem;
    - Supporting the patient in making behavioral changes; and
    - Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

Documentation Requirements: Member medical records must include the following:

- The service provided (e.g., screen and brief intervention)
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record
- The name of the assessment instrument (when indicated)
- The score on the assessment (unless the screening tool is embedded in the electronic health record); and, If and where a referral to an AUD or SUD program was made

If you have any questions or require further clarification regarding SABIRT services or training requirements, please contact your regional Provider Services Representatives.

## Alcohol and Drug Treatment Services

The alcohol and drug treatment services covered by the SD/MC programs include, but are not limited to:

- Outpatient methadone maintenance services
- Outpatient drug-free treatment services
- Daycare habilitative services

- Perinatal residential substance abuse services
- Naltrexone treatment services for opiate addiction

Members receiving alcohol and drug treatment services through the SD/MC program remain enrolled in MHC.

### Referral Documentation

PCPs are responsible for performing all preliminary testing and procedures necessary to determine an appropriate diagnosis. Referrals to SD/MC and/or Fee-For-Service Medi-Cal (FFS/MC) Program should include the appropriate medical records supporting the diagnosis and the required demographic information. After eligibility is approved by the County FFS/MC and/or SD/MC Program, the Member's PCP will submit the requested medical record to assist in the development of a comprehensive treatment plan. A final decision on acceptance of a Member for FFS/MC and/or SD/MC services rests solely with the County Alcohol and Drug Program.

### Criteria for Referral for Alcohol and/or Drug Treatment Services

The need for alcohol and/or drug treatment services is determined by the PCP on the basis of objective and subjective evaluation of the Member's medical history, psychosocial history, current state of health, and any request for such services from either the Member or the Member's family. Various screening tools are included in this Manual to assist the PCP in the detection of substance abuse.

### Referral Process

- The need for alcohol and/or drug treatment services is determined by the PCP on the basis of objective and subjective evaluation of the Member's medical history, psychosocial history, current state of health, and request for such services from either the Member or the Member's family
- Once the determination has been made to refer the Member for alcohol and drug treatment services to a Short-Doyle (SD) Provider/Practitioner or a Fee-For-Service (FFS) Provider/Practitioner, the PCP may make the referral directly or may refer the Member to MHC or its affiliated health plan Medical Case Manager for the coordination of services and follow-up
- According to local preference, referrals are made to a central intake center or directly to a SD/FFS Provider/Practitioner. In both cases, the County Office of Alcohol and Drug Programs will conduct an authorization and review process to determine the appropriate level of care for the Member. The County Office of Alcohol and Drug Programs has determined specific criteria for appropriateness and need for services, including medical or service necessity, focus of care and frequency of service
- When appropriate, the health plan Medical Case Manager coordinates with the MHC Member Services Department and/or Health Education Department to meet a member's cultural and linguistic needs

- Providers/Practitioners seeking guidance in the provision of services to Members with specific cultural needs are referred to the Health Education Department for further assistance when needed
- Daycare Habilitative Services are reimbursable only if they are provided for pregnant or postpartum members and for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible Medi-Cal Members
- SD/MC services within the five treatment modalities referenced may be provided to a Member and billed to the SD/MC program. No other additional treatment services may be authorized and paid within the SD/MC payment system

## PCP's Responsibilities

- PCPs are responsible to act as the primary care practitioner for the Member and to make referrals to medical specialists, as necessary
- The PCP is responsible for performing all preliminary testing and procedures necessary to determine diagnosis. Should the Member require specialty service, the PCP will refer the Member to the appropriate SD/MC alcohol and drug Provider/Practitioner
- The PCP will make available all necessary medical records and documentation relating to the diagnosis and care of the mental health condition prompting the referral
- The PCP will assure that appropriate documentation is in the Member's medical record
- The PCP will screen and thoroughly assess the Member for additional conditions that may directly or indirectly impact the treatment or care of the Member
- PCPs are responsible for coordinating care and services for non-SD/MC related conditions, which may include problems and unmet health care needs directly and indirectly related to or affected by the Member's addiction and lifestyle. This assessment may include medical conditions such as Acquired Immune Deficiency Syndrome (AIDS)/HIV, cirrhosis, tuberculosis, abscesses, sexually transmitted diseases, infections, lack of necessary immunizations, and/or poor nutrition. This assessment may also include psychiatric disorders such as depression, bipolar disorder, and other anti-social personality disorders that contribute to repeating the cycle of addiction and substance abuse

## Criteria for Inpatient Detoxification

A Member will be considered a candidate for referral for acute inpatient detoxification if signs and symptoms are present that suggest the failure to use this level of treatment would be life threatening or cause permanent impairment once substance use is stopped. A Member must have all of the following criteria for inpatient detoxification:

- Fluids and medication to modify or prevent withdrawal complications that threaten life or bodily functions
- 24-hour nursing care with close frequent observation/monitoring of vital signs
- Medical therapy, which is supervised and re-evaluated daily, by the attending physician in order to stabilize the member's physical condition

The Member must exhibit at least two or more of the following symptoms for substance withdrawal:

- Tachycardia
- Hypertension
- Diaphoresis
- Significant increase or decrease in psychomotor activity
- Tremors
- Significantly disturbed sleep patterns
- Nausea/vomiting
- Clouding of consciousness with reduced capacity to shift, focus, and sustain attention

Additionally, criteria for inpatient alcohol detoxification are based on the anticipated severity of the withdrawal as deemed by application of the Revised Clinical Institute Withdrawal Assessment for Alcohol Scale. These tools should be applied as follows:

| POINTS ON SCALE | SEVERITY OF WITHDRAWAL | TREATMENT |
|---|---|---|
| 0 – 5 | No withdrawal | Outpatient |
| 6 – 9 | Mild withdrawal | Outpatient |
| 10 – 14 | Mild-to-moderate withdrawal | Outpatient treatment possible for stable, withdrawal compliant patients with no medical or psychiatric complications and no concurrent abuse of other classes drugs. One day of CHB could be authorized for observation with subsequent assignment either to DCI or outpatient treatment based on reapplication of CIWA-Ar |
| 15 – 19 | Moderate-to-severe withdrawal | Hospitalize for detox. Review CIWA-Ar after three days for re-determination |
| 15 with threatened delirium tremens or score of 20+ | Severe withdrawal | Hospitalize for detox. Review CIWA-Ar after three days for re-determination |

Once the determination and authorization has been made to refer the Member for alcohol and drug treatment services to a SD Provider/Practitioner or an FFS Provider/Practitioner, the PCP may make the referral directly, or may refer the Member to the MHC Case Manager for the coordination of services and follow-up.

According to local preference, referrals are made to a central intake center or directly to a SD/FFS Provider/Practitioner. In both cases, the County Office of Alcohol and Drug Programs will review the case to determine the appropriate level of care for the Member. The County Office of Alcohol and Drug Programs has determined specific criteria for appropriateness and need for services, including medical or service necessity, focus of care, and frequency of service.

## Criteria for Admission to a Residential Facility for Treatment of Substance Use Disorders

Under the SD/MC benefit, covered by county operated program, a Member will be considered a candidate for referral if all of the following indicators apply:

- There is a pattern of substance use that meets the current Diagnostic and Statistical Manual (DSM) criteria for substance use disorder and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities
- The Member is sufficiently medically stable so that the criteria for inpatient detoxification services are not met
- There is clearly documented evidence of the failure of appropriate partial hospitalization or structured outpatient treatment for substance abuse or dependence meeting the current DSM criteria
- The Member's environment or living situation is severely dysfunctional as a result of inadequate or unstable support systems, including the work environment, which may jeopardize successful treatment on an outpatient basis
- There is significant risk of relapse if the Member is treated in a less restrictive care setting related to severely impaired impulse control or a code-morbid disorder

## Criteria for Admission to a Partial Hospital Program for Treatment of Substance Use Disorders

Under the SD/MC benefit, covered by county operated program, a Member will be considered a candidate for referral if all of the following indicators apply:

- There is a clearly documented pattern of substance abuse or dependence that meets the current DSM criteria and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities
- The Member is sufficiently medically stable so that the criteria for inpatient detoxification services are not met
- The Member requires up to eight hours of structured treatment per day in order to obtain the most benefit from coordinated services such as individual, group or family therapy, education, and/or medical supervision
- The Member's environment or living situation and social support system are sufficiently stable to allow for treatment in this care setting
- There is evidence of sufficient motivation for successful participation and treatment in this care setting
- The Member has demonstrated, or there is reason to believe, that the Member can avoid the abuse of substances between treatment sessions based on an assessment of factors such as intensity of cravings, impulse control, judgment, and pattern of use

## Criteria for Admission to a Structured Outpatient Program for Treatment of Substance Use Disorders

Under the SD/MC benefit, covered by county operated program, a Member will be considered a candidate for referral if all of the following indicators apply:

- There is a pattern of substance use that meets the current Diagnostic and Statistical Manual (DSM) criteria for substance use disorder and is severe enough to interfere with social and occupational functioning and causes significant impairment in daily activities
- The Member requires up to four hours of structured treatment per day in order to obtain the most benefit from coordinated services such as individual, group, or family therapy, education, and/or medical supervision
- The Member's environment or living situation and social support system are sufficiently stable to allow for treatment in this care setting
- There is evidence of sufficient motivation for successful participation in treatment in this care setting
- The Member has demonstrated, or there is reason to believe, that the Member can avoid the abuse of substances between treatment sessions based on an assessment of factors such as intensity of cravings, impulse control, judgment and pattern use

## Criteria for Inpatient Chemical Dependency Rehabilitation

Under the SD/MC benefit, covered by county operated program, a Member will be considered a candidate for referral when a combination of the following conditions have been met:

- There is evidence of a substance use disorder as described in the current DSM
- There is evidence of an inability to maintain abstinence outside of a controlled environment
- There is evidence of impairment in social, family, medical, and/or occupational functioning that necessitates skilled observation and care
- There is evidence of need for isolation from the substance of choice and from destructive home influences
- The Member has sufficient mental capacities to comprehend and respond to the content of the treatment program

## Continuity of Care

Providers/Practitioners should provide services in a manner that ensures coordinated and continuous care to all members requiring alcohol and/or drug treatment services including:

- Appropriate and timely referral
- Documenting referral services in the Member's medical record
- Monitoring Members with ongoing substance abuse

- Documenting emergent and urgent encounters, with appropriate follow-up, coordinated discharge planning, and post-discharge care in the Member's medical record

Upon request, MHC Case Management staff will assist in the identification of cases that require coordination of social and health care services.

In the event that the local SD/MC treatment slots are unavailable, the PCP and MHC's Case Management's staff will pursue placement in out-of-network services until the time in-network services become available.

To assure continuity of care when a Member is referred to another Provider/Practitioner, the PCP will transfer pertinent summaries of the Member's medical record to the substance abuse Provider/Practitioner or program and, if appropriate, to the organization where future care will be rendered. Any transfer of Member medical records and/or other pertinent information will be done in a manner consistent with confidentiality standards, including a release of medical records signed by the Member.

Clinical needs and availability of follow-up care will be documented in the Member's medical record. It is recommended that the Member should be in contact with the follow-up therapist or agency prior to discharge from an inpatient facility or outpatient program.

It is expected that Members discharged from a substance abuse inpatient unit will have their follow-up care arranged by the facility's discharge coordinator. MHC recommends that the initial outpatient follow-up appointment occur no later than thirty (30) days after discharge. In addition, the facility discharge coordinator is responsible for notifying the PCP of the Member's impending discharge.

## Confidentiality

- Confidential Member information includes any identifiable information about an individual's character, habits, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. Confidential member information may be learned by a staff member, in either a casual or formal setting, including conversation, computer screen data, faxes, or any written form, all of which will be treated with strict confidence
- MHC and affiliated health plan employees and contracting Providers/Practitioners and their staffs are expected to respect each Member's right of confidentially and to treat the Member information in a respectful, professional, and confidential manner consistent with all applicable Federal and State requirements. Discussion of member information will be limited to that which is necessary to perform the duties of the job
- Applicable MHC policies and procedures include Collection/Confidentiality and Release of Primary Health Care Information and Safeguarding and Protecting Departmental Records

## Problem Resolution

If a disagreement occurs between MHC and the County Office of Alcohol and Drug Programs regarding responsibilities, the Utilization Management Department is notified of the problem. All medical records and correspondence should be forwarded to MHC at:

Molina Healthcare of California
Utilization Management Department
200 Oceangate, Suite 100
Long Beach, CA 90802

Tel: (844) 557-8434
Fax: (800) 811-4804

The Utilization Management Department will:

- Review medical records for issue of discrepancy and discuss with the MHC's Medical Director
- Discuss with the State or County Mental Health Department Office of Alcohol and Drug Programs the discrepancy of authorization and the MHC Clinical Review
- Report MHC's review determination to the County Mental Health Department Office of Alcohol and Drug Programs
- Communicate State or County determinations to the PCP, MHC Medical Director, and other involved parties

## Why Do We Need To Ask About Substance Abuse?

There are many forms of substance use disorder that cause substantial risk or harm to the individual. They include excessive drinking each day, repeated episodes of drinking or using drugs to intoxication, drinking or using drugs that are actually causing physical or mental harm and that has resulted in the person becoming dependent or addicted to the substance being used to excess.

In a primary care practice survey, 15 percent of the patients had a high risk or dependent pattern of alcohol abuse and five percent had the same pattern with other drugs. Studies have shown that up to 25 percent of patients admitted to medical-surgical beds in hospitals either have dependence or abuse of alcohol or drugs. Substance-related disorders in the elderly remain overlooked and undertreated. Up to 16 percent of the elderly have alcohol use disorders. With Americans aged 65 and older constituting the fastest growing segment of our population, this issue becomes increasingly important. Mortality from withdrawal increases with each additional medical condition a person has.

## Screening Tools

Included for your reference are the following:

- Red Flags for alcohol/drug abuse

- Questions to ask patients
- CAGE AID
- Drug use questionnaire (DAST-20)

## Red Flags for Alcohol/Drug Use Disorders

### Observable

1. Tremor/perspiring/tachycardia
2. Evidence of current intoxication
3. Prescription drug seeking behavior
4. Frequent falls; unexplained bruises
5. Diabetes, elevated BP, ulcers
6. Frequent hospitalizations
7. Inflamed, eroded nasal septum
8. Dilated pupils
9. Track marks/injection sites
10. Gunshot/knife wound
11. Suicide talk/attempt, depression
12. Pregnancy (screen all)

### Laboratory

1. MCV - over 95
2. MCH – High
3. GGT – High
4. SGOT – High
5. Bilirubin – High
6. Triglycerides – High
7. Anemia
8. Positive UA for illicit drug use

### CAGE-AID

The CAGE-AID (Adapted to Include Drugs) is a version of the CAGE alcohol screening questionnaire, adapted to include drug use. It assesses likelihood and severity of alcohol and drug abuse.

- Target population: Adults and adolescents
- Evidence:
  - Easy to administer, with good sensitivity and specificity (Leonardson et al. 2005)
  - More sensitive than original CAGE questionnaire for substance abuse (Brown & Rounds 1995)
  - Less biased in term of education, income, and sex then the original CAGE questionnaire (Brown & Rounds 1995)

- Scoring: Each question is scored one point
- A score of one raises suspicion of alcohol or drug abuse
- A score of two+ indicates likelihood of abuse, i.e., alcohol or drug use disorder

CAGE-AID questions to ask patients:

1. Have you ever felt you should Cut Down on drinking or drug use?
2. Have people Annoyed you by criticizing or complaining about your drinking or drug use?
3. Have you ever felt bad or Guilty about your drinking or drug use?
4. Have you ever had a drink or drug in the morning (Eye Opener) to steady your nerves or to get rid of a hangover?
5. Do you use any drugs other than those prescribed by a practitioner?
6. Has a practitioner ever told you to cut down or quit use of alcohol or drugs?
7. Has your drinking/drug use caused family, job, or legal problems?
8. When drinking/using drugs have you ever had a memory loss (blackout)?

## Opioid Dependence

Opioid dependence is characterized by a cluster of cognitive, behavioral and physiological features. The CMS approved diagnostic and procedural code sheet identifies such features:

- A strong desire or sense of compulsion to take opioids
- Difficulties in controlling opioid use
- Physiological withdrawal state
- Tolerance Progressive neglect of alternative pleasures or interests because of opioid use
- Persisting with opioid use despite clear evidence of overtly harmful consequences

CMS approved diagnostic and procedural coding defines opioid dependence as the "presence of three of more [of these features] present simultaneously at any one time in the preceding year." Opioid dependence can include both heroin and prescribed opioids. The criteria for dependence are the same whether the substance is heroin or prescribed pain medications.

Symptoms of opioid intoxication include drooping eyelids and constricted pupils, sedation, reduced respiratory rate, head nodding, and itching and scratching (due to histamine release).

Symptoms of opioid withdrawal include yawning, anxiety, muscle aches, abdominal cramps, headache, dilated pupils, difficulty sleeping, vomiting, diarrhea, piloerection (gooseflesh), agitation, myoclonic jerks, restlessness, delirium, seizures and elevated respiratory rate, blood pressure and pulse.

## Drug Use Questionnaire (DAST-20)

These questions refer to the past 12 months.

| | | | |
|---|---|---|---|
| 1 | Have you ever used drugs other than required for medical reasons? | Yes | No |
| 2 | Have you abused prescription drugs? | Yes | No |
| 3 | Do you abuse more than one drug at a time? | Yes | No |
| 4 | Can you get through the week without using drugs?. | Yes | No |
| 5 | Are you always able to stop using drugs when you want to? | Yes | No |
| 6 | Have you had “blackouts” or “flashbacks” as a result of drug use? | Yes | No |
| 7 | Do you feel bad or guilty about your drug use? | Yes | No |
| 8 | Does your spouse (or parents) ever complain about your involvement with drugs? | Yes | No |
| 9 | Has drug abuse created problems between you and your spouse or your parents? | Yes | No |
| 10 | Have you lost friends because of your drug use? | Yes | No |
| 11 | Have you neglected your family because of your drug use? | Yes | No |
| 12 | Have you been in trouble at work because of drug use? | Yes | No |
| 13 | Have you lost a job because of drug abuse? | Yes | No |
| 14 | Have you gotten into fights when under the influence of drugs? | Yes | No |
| 15 | Have you engaged in illegal activities in order to obtain drugs? | Yes | No |
| 16 | Have you been arrested for possession of illegal drugs? | Yes | No |
| 17 | Have you experienced withdrawal symptoms (felt sick) when you stop taking drugs? | Yes | No |
| 18 | Have you had medical problems as a result of your drug use? (e.g., memory loss, hepatitis, convulsions, bleeding, etc.) | Yes | No |
| 19 | Have you gone to anyone for help for a drug problem? | Yes | No |
| 20 | Have you been involved in a treatment program specifically related to drug use? | Yes | No |

## Detoxification from Alcohol and Drugs

The Substance Abuse and Mental Health Services Administration (SAMHSA) Consensus Panel supports the following statement and has taken special care to note that detoxification is not substance abuse treatment and rehabilitation:

- “Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal. Supervised detoxification may prevent potentially life-threatening complications that might appear if the patient was left untreated. At the same time, detoxification is a form of palliative care (reducing the intensity of a disorder) for those who want to become abstinent or who must observe mandatory abstinence as a result of hospitalization or legal involvement. Finally, for some patients it

represents a point of first contact with the treatment system and the first step to recovery. Treatment/rehabilitation, on the other hand, involves a constellation of ongoing therapeutic services ultimately intended to promote recovery for substance abuse patients."

### References


1. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, Opioid- related disorders - drug therapy. Opioid-related disorders - psychology; Substance abuse - prevention and control; Guidelines. World Health Organization. Dept. of Mental Health and Substance Abuse. ISBN 978 92 4 154754 3 (NLM classification: WM 284)
2. John A. Menninger, MD, Assessment and treatment of alcoholism and substance-related disorders in the elderly, Bulletin of the Menninger Clinic, Volume 66, Issue 2. Spring 2002 Pages 166-183. doi: 10.1521/bumc.66.2.166.23364
3. Brown RL, Rounds LA. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. Wis Med J. 1995; 94: 135-40. http://www.ncbi.nlm.nih.gov/pubmed/7778330


## Major Organ Transplants

Organ transplants are a covered benefit of the Medi-Cal program. Under the GMC, MHC is responsible for identifying and referring patients to Medi-Cal approved facilities for evaluation. MHC retains full responsibility for all major organ transplants (MOT) as a carved-in benefit.

The Medi-Cal program has established specific patient and facility selection criteria for each of the following Medi-Cal major organ transplants:

- Bone marrow transplants
- Heart transplants
- Liver transplants
- Lung transplants
- Heart/lung transplants
- Combined liver and kidney transplants
- Combined liver and small bowel transplants
- Small bowel transplants

### Eligibility

Final authorization of major organ transplants is the responsibility of MHC as a carved-in benefit. Transplants for children under 21 years of age are covered by the California Children's Services (CCS); however, these children are not disenrolled from the plan.

The PCP is responsible for identifying members who are potential candidates for a major organ transplant, for initiating a referral to appropriate specialists and/or

transplant centers, and for coordinating care. The PCP may contact the Medical Director or HCS department of MHC for assistance.

## Referrals

- The PCP will identify members who may be potential candidates for major organ transplant. Following the identification, the PCP will initiate a referral to a specialist and/or Medi-Cal approved transplant center and will continue to provide and coordinate care
- If the transplant center deems the Member to be a potential candidate, the transplant. Provider/Practitioner will submit a request for authorization to MHC (or the CCS Central Office in Sacramento for children and youth under age 21)
- Upon receipt of approval or denial of the transplant authorization request, the transplant center will immediately inform the plan so appropriate action may be taken
- If the request is denied because the Member's medical condition does not meet DHCS criteria, the Plan continues provision for all medically necessary services to the Member
- If the request is approved, the health plan Health Care Services Staff will follow up on all transplant related services, including organ procurement, transplantation, and travel related expenses from the time the member is listed through six months post transplantation.  after the following steps have occurred:
    - The health plan HCS staff has approved a referral of the Member to a Medi-Cal designated transplant center for evaluation
    - The transplant center Provider/Practitioner(s) has performed a pre-transplant evaluation on the Plan Member and the center's Patient Selection Committee has determined the member to be a suitable candidate for transplant
    - The transplant center Provider/Practitioner(s) has submitted a prior authorization request to MHC and the transplant procedure has been approved and documentation sent to the health plan Case Management Staff by the transplant center
- In the event of the necessity for an emergency organ transplant, MHC's HCS Staff will assure that medically necessary transplant services are provided in a Medi-Cal designated transplant center and that an authorization is approved.
- MHC is responsible for all costs of covered medical care, including those for transplant evaluation, organ acquisition and post-transplant care., PCPs are responsible for continuity of care during the transition period and for transferring all medical records to the transplant Provider/Practitioner
- Coordination of care is managed by the PCP, who is assisted by a health plan Case Manager

The PCP has primary responsibility for the coordination of care:

- Identification of potential Major Organ Transplants candidates
- Provision of primary medical care
- Referral to appropriate specialty care Provider/Practitioner
- Review of all medical records and reports received from transplant center

- Providing education to member regarding his/her condition
- Reinforcing the transplant team's treatment plan
- Referring member to additional psychosocial support resources as needed
- Provide all required documentation to the transplant center

The health plan HCS staff is responsible for the following:

- Referral to a contracted major organ transplant center and ensuring the appointment is scheduled appropriately
- Ensuring transfer of pertinent medical records to transplant center
- Communicating written or verbally as necessary
- Ensuring the transplant center evaluation appointment is kept by the member
- Tracking each phase of the referral process to the transplant center(s)
- The health plan's Medical Director, HCS staff, Case Manager, and member's PCP (and Specialist if applicable) will continue to manage and coordinate member's health care needs with a contracted transplant center
- The transplant center Provider/Practitioner has performed a pre-transplant evaluation on the Member and the center's Patient Selection Committee has determined the Member to be a suitable candidate for transplant
- The transplant center Provider/Practitioner has submitted a prior authorization request and the transplant procedure has been approved
- Should an emergency organ transplant be necessary, MHC HCS Staff will ensure that medically necessary transplant services are provided in a Medi-Cal designated transplant center

### PCP's Responsibility

PCPs are responsible for ensuring continuity of care during the transition period and for transferring all medical records to the transplant Provider/Practitioner in a timely manner.

It is the responsibility of the PCP to refer any member who is a potential transplant candidate to the MHC HCS Department. Please contact the appropriate Case Management Department as follows:

Molina Healthcare
Tel: (800) 526-8196, Ext. 127604
Fax: (888) 273-1735

### Renal Transplants

Renal transplants for members 21 years and over are a covered benefit. The PCP and Case Management Staff will refer the identified member to a DHCS licensed and certified hospital with a renal transplant unit. The PCP is responsible for the coordination of all necessary primary care services and for the provision of all services related to renal transplantation, including the evaluation of potential donors and nephrectomy from living or cadaver donors.

Members under age 21 years in need of evaluation as potential renal transplant candidates will be referred to the appropriate CCS program office for a referral to an approved CCS renal dialysis and transplant center. Requests for renal transplants from CCS approved renal dialysis and treatment centers will be sent to the local CCS Program Office for authorization. The PCP and health plan's Pediatric/CCS Staff will coordinate the referral to the CCS Program Office.

MHC remains responsible for the provision of primary care services and for coordination of care with CCS regarding renal transplant services.

# 17. HEALTHCARE SERVICES: MENTAL HEALTH/SHORT-DOYLE COORDINATION & SERVICES

Effective January 1, 2014, as established in W&I Code Sections (§§) 14132.03 and 14189, Medi-Cal managed care plans, including MHC and contracted network providers, are required to cover certain outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health diagnosis, as defined in the current Diagnostic and Statistical Manual, except relational problems (i.e., couples counseling or family counseling for relational problems).

As of October 1, 2017, the Medicaid Mental Health Parity Final Rule (CMS-2333-F), establishes the regulatory requirements for the provision of medically necessary non-specialty mental health services to children under the age of 21. The number of visits for mental health services is not limited as long as the MHC beneficiary meets medical necessity criteria. MHC provides direct access to an initial mental health assessment by a licensed mental health provider within network. Referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provided is not required.

As of January 1, 2014, MHC is offering the following expanded mental health services to Medi-Cal managed care members meeting medical necessity or Early Periodic Screening Diagnosis and Treatment (EPSDT) and/or members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health diagnosis, as defined in the current Diagnostic and Statistical Manual, except relational problems (i.e., couples counseling or family counseling for relational problems):

- Individual and group mental health evaluation and treatment (psychotherapy)
- Family therapy (non-relational problems)
- Psychological testing to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication therapy
- Outpatient services that include laboratory work, medications (excluding anti-psychotic drugs which are covered by Medi-Cal FFS), supplies and supplements
- Psychiatric consultation
- Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment

The following specialty mental health services are excluded from MHC's coverage responsibility but will continue to be provided by the County mental health agencies for members who meet medical necessity criteria or EPSDT and/or members with severe impairment of mental, emotional, or behavioral functioning resulting from a mental health diagnosis. MHC contracted providers should direct members who are receiving or eligible for such services to County mental health/behavioral health services.

- Outpatient services

    - Mental health services, including assessments, plan development, therapy and rehabilitation, and collateral
    - Medication support
    - Day treatment services and day rehabilitation
    - Crisis intervention and stabilization
    - Targeted case management
    - Therapeutic behavior services
- Residential services
    - Adult residential treatment services
    - Crisis residential treatment services
- Inpatient services
    - Acute psychiatric inpatient hospital services
    - Psychiatric inpatient hospital professional services.
    - Psychiatric health facility services.

The following services are excluded from MHC's coverage responsibility, but are provided by County Alcohol and Other Drug (AOD) programs:

- Outpatient services
    - Outpatient drug-free program.
    - Intensive outpatient (newly expanded to additional populations).
    - Residential services (newly expanded to additional populations).
    - Narcotic treatment program.
    - Naltrexone
    - Voluntary inpatient detoxification

Primary care providers continue to be responsible for screening and brief intervention, and in performing all preliminary evaluations necessary to develop a diagnosis prior to referring member to applicable county agency or program. Screening tools are available on the DHCS and our provider website at: www.MolinaHealthcare.com.Screening tools include the Staying Healthy Assessment (SHA)/Individual Health Education Behavioral Assessment (IHEBA). Please refer to the released guidelines regarding the use of the IHEBA in Policy Letter (PL) 13-001 (Revised) and the "New Requirements for the Staying Healthy Assessment/Individual Health Education Behavioral Assessment."

### Psychiatric Scope of Services for the PCP

These services are limited; examples of services that are generally considered psychiatric primary care services are listed below. However, the PCP must have received appropriate training and provide only those services consistent with State and Federal regulations and statutes:

- Perform complete physical and mental status examinations and extended psychosocial and developmental histories when indicated by psychiatric or somatic presentations (fatigue, anorexia, over-eating, headaches, pains, digestive problems, altered sleep patterns, and acquired sexual problems)
- Diagnose physical disorders with behavioral manifestations

- Provide maintenance medication management after stabilization by a psychiatrist or if longer-term psychotherapy continues with a non-Practitioner therapist
- Diagnose and manage child/elder/dependent-adult abuse and victims of domestic violence
- Screening for depression for pregnant and post-partum patients and referral to treatment when indicated

### PCP Responsibilities – Primary Caregiver and Referrals

PCPs will provide outpatient mental health services within their scope of practice. Should the Member's mental health needs require specialty mental health services (as indicated above), the PCP should refer the Member to the County Mental Health Department for assessment and referral to an appropriate mental health Provider/Practitioner.

The PCP will make available all necessary medical records and documentation relating to the diagnosis and care of the mental health condition resulting in a referral.

The PCP will assure appropriate documentation in the Member's medical record. The PCP will coordinate non- SD/MC conditions and services with specialists as necessary.

### Continuation of Care

PCPs will provide services and referrals in a manner that ensures coordinated and continuous care to all Members needing mental health services, including appropriate and timely referral, documentation of referral services, monitoring of Members with ongoing medical conditions, documentation of emergency and urgent encounters with appropriate follow-up, coordinated discharge planning, and post-discharge care.

To assure continuity of care when a Member is referred to another Provider/Practitioner, the PCP will transfer pertinent summaries of the Member's records to that health care Provider/ Practitioner and, if appropriate, to the organization where future care will be rendered. Any transfer of Member medical records and/or other pertinent information should be done in a manner consistent with confidentiality standards including a release of the medical records signed by the Member.

### Confidentiality

Confidential Member information includes any identifiable information about an individual's character, habits, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment.

It is the policy of MHC that all of its employees and contracting Provider/Practitioners respect each Member's right of confidentiality and treat the Member information in a respectful, professional, and confidential manner consistent with all applicable Federal and State requirements. Discussion of member information should be limited to that which is necessary to perform the duties of the job.

Reports from specialty services and consultations are placed in the patient's chart at the PCP's office. Mental health services are considered confidential and sensitive. Any follow-up consultation that the PCP receives from the specialist or therapist is placed in the confidential envelope section of the Member's medical record. Please refer to MHC Policy and Procedure MR-26, Collection/Use/Confidentiality, and Release of Primary Health Information and MS-07, Safeguarding and Protecting Medical Records.

## Problem Resolution

If a disagreement occurs between MHC and the California Department of Mental Health regarding responsibilities, the Utilization Management Department is notified. All medical records and correspondence should be forwarded to:

Molina Healthcare of California
Attn: Utilization Management Department
200 Oceangate, Suite 100
Long Beach, CA 90802

Tel: (844) 557-8434
Fax: (800) 811-4804

The Utilization Management Department shall:

- Review medical records for issue of discrepancy and discuss with MHC Medical Director
- Discuss with the California Department of Mental Health the discrepancy of authorization responsibility and the MHC clinical review determinations
- MHC will authorize all services that are medically necessary that are not excluded from the contract agreement for Medi-Cal managed care
- If a dispute cannot be resolved to the satisfaction of the California Department of Mental Health or MHC, a request by either party may be submitted to the Department of Health Care Services within 15 calendar days of the completion of the dispute resolution process outlined in the applicable Memorandum of Understanding (MOU) (the request for resolution shall contain the items identified in Title 9. CCR Section 1850.505)
- MHC will communicate issues and determinations to the PCP and other involved parties

# 18. HEALTHCARE SERVICES: BREAST & PROSTATE CANCER TREATMENT INFORMATION REQUIREMENTS

## Special Requirements for Information and/or Consent for Breast and Prostate Cancer Treatment

### Breast Cancer Consent Requirements

A standardized summary discussing alternative breast cancer treatments and their risks and benefits must be given to patients. A brochure has been prepared to accomplish this task and is available at the following address:

Medical Board of California
Breast Cancer Treatment Options
1426 Howe Street, Suite 54
Sacramento, CA 95825

Order requests can be faxed to (916) 263-2479. There is no charge for the brochure, and it is available in bundles of 25, up to a maximum of two cases – 250 copies per case. It is available in the following languages: English, Spanish, Korean, Chinese, Russian, and Thai.

The brochure should be given to the patient before a biopsy is taken, whether or not treatment for breast cancer is planned or given. The brochure may not supplant the physician's duty to obtain the patient's informed consent. In addition to the distribution of the brochure, physicians should discuss the material risks, benefits, and possible alternatives of the planned procedure(s) with the patient and document such discussion in the medical record of the patient. Failure to provide the required information constitutes unprofessional conduct.

Every physician who screens or performs biopsies for breast cancer must post a sign with prescribed wording relating to the above brochure. The sign or notice shall read as follows:

**"BE INFORMED"**

"If you are a patient being treated for any form of breast cancer, or prior to performance of a biopsy for breast cancer, your physician and surgeon is required to provide you a written summary of alternative efficacious methods of treatment, pursuant to Section 109275 of the California Health and Safety Code."

"The information about methods of treatment was developed by the State Department of Health Care Services to inform patients of the advantages, disadvantages, risks, and descriptions of procedures."

The sign must be posted close to the area where the breast cancer screening or biopsy is performed or at the patient registration area. The sign must be at least 8 1/2" X 11" and conspicuously displayed so as to be readable. The words "BE INFORMED" shall

not be less than one-half inch in height and shall be centered on a single line with no other text. The message on the sign shall appear in English, Spanish, and Chinese.

## Prostate Cancer Screening and Treatment Information to Patients

Providers/Practitioners are required to tell patients receiving a digital rectal exam that a prostate-specific antigen (P.S.A.) test is available for prostate cancer detection.

The National Institute of Health currently provides a prostate cancer brochure entitled: "What You Need to Know about Prostate Cancer." It is available by calling (800) 4CANCER. Brochures can also be ordered by going online to www.cancer.gov or faxing an order to (301) 330-7968. The first 20 brochures are free and there is a $.15/brochure fee for orders over 20, with a minimum order of $8.00.

Every physician who screens for or treats prostate cancer must post a sign with prescribed wording referencing this information. The sign or notice shall read as follows:

**"BE INFORMED"**

"If you are a patient being treated for any form of prostate cancer, or prior to performance of a biopsy for prostate cancer, your physician and surgeon is urged to provide you a written summary of alternative efficacious methods of treatment, pursuant to Section 109280 of the California Health and Safety Code."

"The information about methods of treatment was developed by the State Department of Health Care Services to inform patients of advantages, disadvantages, risks, and descriptions of procedures."

The sign must be posted close to the area where the prostate cancer screening or treatment is performed or at the patient registration area. The sign must be at least 8 1/2" X 11" and conspicuously displayed so as to be readable. The words "BE INFORMED" shall not be less than one-half inch in height and shall be centered on a single line with no other text. The message on the sign shall appear in English, Spanish, and Chinese. The sign shall include the internet web site address of the State Department of Health Care Services and the Medical Board of California and a notice regarding the availability of updated prostate cancer summaries on these web sites.

## Information for Patients

The California Department of Public Health (CDPH) has information about breast and prostate cancer on their website at: http://www.cdph.ca.gov/HealthInfo/Pages/BreastCancerInformation.aspx.

Information can be viewed or printed from this website.

# 19. HEALTHCARE SERVICES: HUMAN REPRODUCTIVE STERILIZATION PROCEDURE AND CONSENT

Members must be appropriately and adequately informed about human reproductive sterilization procedures. Informed consent must be obtained prior to performing a procedure that renders a person incapable of producing children. Sterilization performed because pregnancy would be life threatening to the mother is included in this requirement. When sterilization is the unavoidable secondary result of a medical procedure and the procedure is not being done in order to achieve that secondary result, the procedure is not included in this policy.

## Conditions for Sterilization

Sterilization may be performed only under the following conditions:

- The Member is at least 21 years old at the time the consent is obtained
- The Member is not mentally incompetent, as defined by Title 22, i.e., an individual who has been declared mentally incompetent by a Federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared incompetent for purposes which include the ability to consent to sterilization
- The Member is able to understand the content and nature of the informed consent process
- The Member is not institutionalized, as defined by Title 22, i.e., someone who is involuntarily confined or detained, under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness
- The Member has voluntarily given informed consent in accordance with all of the prescribed requirements
- At least 30 days, but not more than 180 days, have passed between the date of written informed consent and the date of the sterilization. Exceptions are addressed below

## Conditions When Informed Consent May Not Be Obtained

Informed consent may not be obtained while the member to be sterilized is:

- In labor or within 24 hours postpartum or post-abortion
- Seeking to obtain or obtaining an abortion
- Under the influence of alcohol or other substances that affect the member's state of awareness

## Informed Consent Process Requirements

The following criteria, including the verbal and written member information requirements, must be met for compliance with the informed consent process:

- The informed consent process may be conducted either by Provider/Practitioner or appropriate designee
- Suitable arrangements must be made to ensure that the information specified above is effectively communicated to any individual who is deaf, blind, or otherwise handicapped
- An interpreter must be provided if the member to be sterilized does not understand the language used on the consent form or the language used by the person obtaining the consent
- The member to be sterilized must be permitted to have a witness present of that member's choice when consent is obtained
- The sterilization procedure must be requested without fraud, duress, or undue influence

## Required Member Information

The Member requesting to be sterilized must be provided with the appropriate booklet on sterilization published by the Department of Health Care Services (DHCS) BEFORE THE CONSENT IS OBTAINED. These are the only information booklets approved by DHCS for distribution to individuals who are considering sterilization:

- "Understanding Sterilization for a Woman"
- "Entendiendo La Esterilizacion Para La Mujer"
- "Understanding Vasectomy"
- "Entendiendo La Vasectomia"

Providers/Practitioners may obtain copies of the information booklets provided to Members in English or Spanish by submitting a request on letterhead to:

California Department of Health Care Services
Warehouse - Forms Processing
1037 North Market Blvd., Suite 9
Sacramento, CA 95834

Fax: (916) 928-1326

When the Providers/Practitioners or appropriate designee obtains consent for the sterilization procedure, he/she must offer to answer any questions the Member to be sterilized may have concerning the procedure. In addition, all of the following must be provided verbally to the Member who is seeking sterilization:

- Advice that the Member is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits, he/she is entitled to
- A full description of available alternative methods of family planning and birth control
- Advice that the sterilization procedure is considered irreversible
- A thorough explanation of the specific sterilization procedure to be performed

- A full description of discomforts and risks that may accompany or follow the procedure, including explanation of the type and possible side effects of any anesthetic to be used
- A full description of the benefits or advantages that may be expected from sterilization
- Approximate length of hospital stay and approximate length of time for recovery
- Financial cost to the member. Information that the procedure is established or new
- Advice that sterilization will not be performed for at least 30 days, except in the case of emergency abdominal surgery or premature birth (when specific criteria are met)
- The name of the Provider/Practitioner performing the procedure. If another Provider/ Practitioner is to be substituted, the member will be notified, prior to administering pre-anesthetic medication, of the Provider/Practitioner's name and the reason for the change in Provider/Practitioner

The required consent form PM 330 must be fully and correctly completed after the above conversation has occurred. Consent form PM 330, provided by DHCS in English and Spanish, is the ONLY form approved by DHCS.

The PM 330 must be signed and dated by:

- The Member to be sterilized
- The interpreter, if utilized in the consent process
- The person who obtained the consent
- The Provider/Practitioner performing the sterilization procedure

By signing consent form PM 330, the person securing the consent certifies that he/she has personally:

- Advised the Member to be sterilized, before that Member has signed the consent form, that no Federal benefits may be withdrawn because of a decision not to be sterilized
- Explained verbally the requirements for informed consent to the Member to be sterilized as set forth on the consent form PM 330
- Determined to the best of his/her knowledge and belief, that the Member to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized

The Provider/Practitioner performing the sterilization certifies, by signing the consent form PM 330, that:

- The Provider/Practitioner, within 72 hours prior to the time the Member receives any preoperative medication, advised the member to be sterilized that Federal benefits would not be withheld or withdrawn because of a decision not to be sterilized
- The Provider/Practitioner explained verbally the requirements for informed consent as set forth on the consent form PM 330
- To the best of the Provider/Practitioner's knowledge and belief, the Member to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized

- At least 30 days have passed between the date of the Member's signature on the consent form PM 330 and the date upon which the sterilization was performed, except in the case of emergency abdominal surgery or premature birth, and then only when specific criteria is met

The interpreter, if one is utilized in the consent process, will sign the consent form PM 330 to certify that:

- The interpreter transmitted the information and advice presented verbally to the Member
- The interpreter read the consent form PM 330 and explained its content to the Member
- The interpreter determined, to the best of the interpreter's knowledge and belief, that the Member to be sterilized understood the translated information/instructions

## Medical Record Documentation

There must be documentation in the progress notes of the Member's medical record that a discussion regarding sterilization has taken place, including the answers given to specific questions or concerns expressed by the Member. It will be documented that the booklet and copy of the consent form were given to the Member. The original signed consent form must be filed in the Member's medical record. A copy of the signed consent form must be given to the Member and a copy is placed in the Member's hospital medical record at the facility where the procedure is performed.

If the procedure is a hysterectomy, a copy of the informed consent form for hysterectomy should be placed in the Member's medical record. This form is supplied by the facility performing the procedure.

## Office Documentation

All participating Providers/Practitioners are responsible for maintaining a log of all human reproductive sterilization procedures performed. A sample of sterilization log is provided for your reference. This log must indicate the Member's name, date of sterilization procedure, the member's medical record number, and the type of procedure performed.

## Exceptions to Time Limitations

Sterilization may be performed at the time of emergency abdominal surgery or premature delivery if the following requirements are met:

- A minimum of 72 hours have passed after written informed consent to be sterilized, and,
- A written informed consent for sterilization was given at least 30 days before the member originally intended to be sterilized, or,
- A written informed consent was given at least 30 days before the expected date of delivery

## Special Considerations, Hysterectomy

A hysterectomy will not be performed solely for the purpose of rendering an individual permanently sterile. If a hysterectomy is performed, a hysterectomy consent form must be completed in addition to other required forms.

## Noncompliance

The Quality Improvement Department monitors compliance for the consent process of human reproductive sterilization. Identified deficiencies will be remedied through a course of corrective action(s) as determined appropriate by the Quality Improvement Committee with following reviews conducted to assess improvement or continued. The DHCS also performs audits for compliance with Title 22. Both MHC and DHCS are required to report non-complaint Providers/Practitioners to the Medical Board of California.

## Ordering of Consent Forms

Sterilization consent forms PM 330, with English printed on one side and Spanish on the other side, can be ordered directly from DHCS by sending a request to:

Medi-Cal Benefits Branch
California Department of Health Care Services
714 P Street, Room 1640
Sacramento, CA 95814

# 20. BEHAVIORAL HEALTH

## Overview

Molina provides a Behavioral Health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty Providers to ensure whole person care. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

## Utilization Management and Prior Authorization

Behavioral Health i Autism Services, Psychological Testing, Neurological Testing services can be requested by submitting a Prior Authorization Request form or contacting Molina's Prior Authorization team at (800) 811- 4804. Providers requesting after-hours authorization for these services should utilize Availity Essentials Portal or fax submission options. Emergency psychiatric services do not require Prior Authorization. All requests for Behavioral Health services should include the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted Medical Necessity criteria for Prior Authorization reviews. Please see the Prior Authorization subsection found in the Health Care Services section of this Provider Manual for additional information.

## Access to Behavioral Health Providers and PCPs

Members may be linked to an in-network Behavioral Health Provider via referral from a PCP or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of, or referral for, any known or suspected Behavioral Health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health service within the scope of their practice. A formal referral form or Prior Authorization is not needed for a Member to self-refer or be referred to a PCP or Behavioral Health Provider.

Behavioral Health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Members may be referred to a PCP and specialty care Providers to manage their health care needs. Behavioral Health Providers may identify other health concerns, including physical health concerns, that should be addressed by referring the Member to a PCP.

Members call Molina for assistance linking to initial behavioral health services will be screened using a state standardized tool to determine linkage with Specialty or Non-Specialty Mental Health Services (SMHS or NSMH). SMHS are services provided by County Mental Health Plans, and NSMHS are provided by Molina.

# Care Coordination and Continuity of Care

## Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge.

## Interdisciplinary Care Coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Molina's Care Management program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

## Care Management

Molina's Care Management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and SUD needs. Members with high-risk psychiatric, medical or psychosocial needs may be referred by a Behavioral Health Provider to the CM program.

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

Email: CMEscalationCA@MolinaHealthcare.com (adults)
Email: MHCHealthcareservicesccs/rccasemanagement@MolinaHealthcare.com (children/youth)
Phone: 800-526-8196, Ext: 127604
Fax: 562-499-6105

Additional information on the CM program can be found in the Care Management subsection found in the Health Care Services section of this Provider Manual.

## Responsibilities of Behavioral Health Providers

Molina promotes collaboration with Providers and integration of both physical and behavioral health services in effort to provide quality care coordination to Members. Behavioral Health Providers are expected to provide in-scope, evidence-based mental health and substance use disorder services to Molina Members. Behavioral Health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow Quality standards related to access. Molina provides oversight of Providers to ensure Members are able to obtain needed health services within the

acceptable appointment timeframes. Please see the Quality section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

### Behavioral Health Crisis Line

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24/7 year-round. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling the Member Services telephone number listed on the back of their Molina Member ID card.

### National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone worried about someone else), can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year, by dialing 988 from any phone.

### Behavioral Health Tool Kit for Providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to Behavioral Health HEDIS® Tip Sheets and other evidence-based guidance, and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both primary care and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the “Health Resources” tab on the MolinaHealthcare.com Provider website.

# 21. PHARMACY

The Pharmacy benefit has been carved out from California Managed MediCal Plans to Medi-Cal Rx.

Medi-Cal Rx will administer the Pharmacy benefit as directed by Department of Health Services (DHCS), including:

- Drug Formulary
- Contracted Drug List
- Drug Prior Authorization
- Drug Appeals
- Pharmacy Network

The Medi-Cal Rx Availity Essentials portal: provider.MolinaHealthcare.com

will allow Providers access to pharmacy services tools for:

- Beneficiary Eligibility Lookup
- Web Claims Submission
- Prior Authorization Submission and Inquiry
- Learning Management System
- Secure Message Center
- Secure Chat

For more information on the Medi-Cal Rx Program and Portal go to, https://medi-calrx.dhcs.ca.gov/. Molina Health Plan will remain responsible for Physician Administered Drugs (PADs) billed on a medical claim, as pharmacy items billed on a pharmacy claim can be submitted to Medi-Cal Rx.

“Buy and Bill” drugs are Physician Administered Drugs (PADs), which a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursement.

# 22. CLAIMS & COMPENSATION

| Payer ID | 38333 |
|---|---|
| Availity Essential Portal | provider.MolinaHealthcare.com |
| Clean Claim Timely Filling | 90 calendar days after the discharge for inpatient services or the Date of Service for outpatient services |

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

**Molina offers the following electronic Claims submission options:**

- Submit Claims directly to Molina via the Availity Essentials portal.
- Submit Claims to Molina via your regular EDI clearinghouse.

### Availity Essentials Portal

The Availity Essentials portal is a no cost online platform that offers a number of Claims processing features:

- Submit Professional (CMS1500) and Institutional (CMS-1450 [UB04]) Claims with attached files.
- Correct/Void Claims.
- Add attachments to previously submitted Claims.
- Check Claims status.
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
- 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.

If you do not have a clearinghouse, Molina offers additional electronic claims submissions options as shown by logging on to the Availity Essentials portal.

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

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 277CA response file with initial status of the Claims from your clearinghouse.
- You should refer to the Molina Companion Guide for information on the response format and messages.
- 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 should contact their Provider Services representative for additional support.

## 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.

## 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 Availity Essentials 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). 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.

## 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.

## Required Elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5.

The following information must be included on every claim, whether electronic or paper:

- 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)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Rendering Provider information when different than billing
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)

- Disclosure of any other health benefit plans
- National Drug Code (NDC), unit of measure and quantity for medical injectables
- E-signature
- Service Facility Location information

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

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

## EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called “Claim frequency codes.” Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

| Claim Frequency Code | Description | Action |
|---|---|---|
| 7 | Use to replace an entire Claim. | Molina will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim. |
| 8 | Use to eliminate a previously submitted Claim. | Molina will void the original Claim from records based on request. |

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number, must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original Claim number, adjustment requests will generate a compliance error and the Claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original Claim number will not be adjusted.

## 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 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, please submit paper claims to the following address:

Molina Healthcare of California
PO Box 22702
Long Beach, CA 90801

Please keep the following in mind when submitting paper claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are **required** to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- 
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10- or 12-point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

## Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms. The descriptions of each field for a CMS-1500.

Molina strongly encourages participating Providers to submit Corrected Claims electronically via EDI or the Availity Essentials portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.

- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms or the UB Editor (Uniform Billing Editor) for CMS-1450 (UB-04) Claim forms.

Corrected Claims must be sent within 90 calendar days of the date of service of the Claim.

## Corrected Claims submission options:

- Submit Corrected Claims directly to Molina via the Availity Essentials portal.
- Submit corrected Claims to Molina via your regular EDI clearinghouse.

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

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

### COB

Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina Members. If third party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for secondary Claim processing. In the event that coordination of benefits occurs, Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Molina will pay claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third party policy information required for billing.

Subrogation - Molina retains the right to recover benefits paid for a Member’s health care services when a third party is responsible for the Member’s injury or illness to the extent permitted under State and Federal law and the Member’s benefit plan. If third party liability is suspected or known, please refer pertinent case information to Molina's vendor at: Optum: submitreferrals@optum.com

## 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.) Non-Ketotic Hyperosmolar Coma
    d.) Secondary Diabetes with Ketoacidosis
    e.) Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures:
    a.) Spine
    b.) Neck
    c.) Shoulder
    d.) Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a.) Laparoscopic Gastric Restrictive Surgery
    b.) Laparoscopic Gastric Bypass
    c.) Gastroenterostomy

12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Latrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a.) Total Knee Replacement
    b.) Hip Replacement

### What this means to Providers

- Acute IPPS Hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing
- 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/.

## Molina Coding Policies and Payment Policies

Frequently requested information on Molina's Coding Policies and Payment Policies is available on the MolinaHealthcare.com website under the Policies tab. Questions can be directed to your Provider Services representative.

## Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. Molina requires coding of both diagnoses and procedures for all Claims as follows:

For diagnoses the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM.

For procedures:

- Professional and outpatient Claims require the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 Healthcare Common Procedure Coding System (HCPCS codes)
- 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 as well as administers payment rules based on

generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- 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.
- 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 in accordance with applicable billing guidelines.

For guidance, please refer to the resources located at: Medicine: Telehealth (medne tele) (ca.gov), to telehealth guidelines and/or Medicaid regulatory agency provider manual;

Services as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health care service plan and the provider shall ensure the rate is consistent with subdivision (h) of Section 1367.

Molina will reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of a Molina member appropriately delivered through telehealth services on the same basis and to the same extend that Molina is responsible

for reimbursement for the same service through in-person diagnosis consultation, or treatment.

## 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. Molina uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to 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 the 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 code books.

## ICD-10-CM/PCS Codes

Molina utilizes 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 CMS-1450 (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 CMS-1450 (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 National Drug Code number (NDC) must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, CMS-1450 (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. There are three types of CPT codes:

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

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

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

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

Priority Social Determinants of health (SDOH) Codes to collect reliable SDOH data.

DHCS issued a list of 18 DHCS Priority SDOH Codes, based on the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for providers to utilize when coding for SDOH to ensure correct coding and reliable data.

### DHCS Priority SDOH Codes

| Code | Description |
|---|---|
| Z55.0 | Illiteracy and low-level literacy |
| Z58.6 | Inadequate drinking-water supply |
| Z59.00 | Homelessness unspecified |
| Z59.01 | Sheltered homelessness |
| Z59.02 | Unsheltered homelessness |
| Z59.1 | Inadequate housing (lack of heating/space, unsatisfactory surroundings) |
| Z59.3 | Problems related to living in residential institution |
| Z59.41 | Food insecurity |
| Z59.48 | Other specified lack of adequate food |
| Z59.7 | Insufficient social insurance and welfare support |
| Z59.811 | Housing instability, housed, with risk of homelessness |
| Z59.812 | Housing instability, housed, homelessness in past 12 months |
| Z59.819 | Housing instability, housed unspecified |
| Z59.89 | Other problems related to housing and economic circumstances |
| Z60.2 | Problems related to living alone |
| Z60.4 | Social exclusion and rejection (physical appearance, illness or behavior) |
| Z62.819 | Personal history of unspecified abuse in childhood |
| Z63.0 | Problems in relationship with spouse or partner |
| Z63.4 | Disappearance & death of family member (assumed death, bereavement) |
| Z63.5 | Disruption of family by separation and divorce (marital estrangement) |
| Z63.6 | Dependent relative needing care at home |
| Z63.72 | Alcoholism and drug addiction in family |
| Z65.1 | Imprisonment and other incarceration |
| Z65.2 | Problems related to release from prison |
| Z65.8 | Other specified problems related to psychosocial circumstances (religious orspiritual problem) |

## 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 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 Molina, or Molina's 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.

## Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the Claim for service within 45 business days after receipt of Clean Claims.

The receipt date of a Claim is the date Molina receives notice of the Claim.

## Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at: MolinaHealthcare.com or by contacting our Provider Services department.

## Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. dispute overpayment findings.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For members with Commercial COB, Molina will provide notice within 270 days from the claim's paid date if the primary insurer is a Commercial plan. For members with Medicare COB Molina will provide notice within 540 days from the claim's paid date if the primary insurer is a Medicare plan. A provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the overpayment amount(s) against future payments made to the Provider.

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

## Claim Disputes/Reconsiderations/Appeals

Providers disputing a Claim previously adjudicated must request such action within 365 days of Molina’s original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider website and the Availity Essentials portal: provider.MolinaHealthcare.com

The form must be filled out completely in order to be processed.

Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
- The Claim number clearly marked on all supporting documents.

Requests for Claims Disputes/Reconsiderations should be sent via the following methods:

Forms may be submitted via fax, secure email or mail. Claims Disputes/Reconsideration requested via the CRRF may be sent to the following address:

Molina Healthcare of California
Attention: Claims Disputes/Adjustments
PO Box 22722
Long Beach, CA 90802

Submitted via Fax: (562) 499-0633

Electronic Submission for single claim disputes can be uploaded via the Availity Essentials portal.

Please Note: Requests for adjustments of Claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original Claim.

The Provider will be notified of Molina's decision in writing within 45 days of receipt of the Claims Dispute/Adjustment request.

## Balance Billing

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 Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

## Fraud, Waste, and Abuse

Failure to report instances of suspected fraud, waste, 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 and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least once a month and within 60 days from the date of service in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

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 which 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.

# 23. ENCOUNTER DATA

## Encounter Data Incentives, CHDP/EPSDT Incentives

### Encounter Reporting

The collection of encounter data is vital to Molina Healthcare of California (MHC). Encounter data provides the Plan with information regarding all services provided to our membership. Encounter data serves several critical needs. It provides:

- Information on the utilization of services
- Information for use in HEDIS studies
- Information that fulfills state reporting requirements

DHCS has implemented standards for the consistent and timely submission of Medi-Cal encounter data. Providers must submit accurate and timely encounter data of the rendered service. MHC is required to submit encounter information to DHCS.

### HIPAA Standards for Electronic Transactions

HIPAA required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. All covered entities must be in compliance with the electronic transactions and code sets standards by October 16, 2003. Covered entities include:

- health plans,
- health care providers who transmit health information in electronic form in connection with a transaction covered by HIPAA, and,
- Health care clearinghouses

The electronic health care transactions covered under HIPAA that may affect provider organizations are:

| TRANSACTION DESCRIPTION | HIPAA TRANSACTION STANDARD |
|---|---|
| Claims or Encounter Information | ASC X12N 837, Professional, or Institutional Health Care Claims or Encounter ((005010X222A1/005010X223A2/005010X224A2)) |
| Eligibility for a Health Plan | ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response (005010X279A1 |
| Referral Certification and Authorization | ASC X12N 278 Health Care Services Review Request for Review and Response (005010X217E2) |
| Claims Status | ASC X12N 276/277 Health Care Claim Status Request and Response ((005010X212E2) |
| Payment and Remittance Advice | ASC X12N 835 Health Care Claim Payment/Advice (005010X221A1) |

## HIPAA Provider Hotline Contact Information

For HIPAA TCS questions please call the Toll-Free HIPAA Provider Hotline at: (866) 665-4622. You may also obtain information on the MHC website at: MolinaHealthcare.com.

## Policy

MHC requires all Providers/Practitioners and delegated entities to submit encounter data reflecting the care and services provided to our Members.

This policy applies to all Primary Care Practitioners (PCPs), contracted either directly with MHC or through an IPA/Medical Group and delegated entities required to submit encounters. It is important to note the encounter data must also reflect services provided by any ancillary personnel that are under the direction of the PCP, including any physicians (specialists) providing care and services to our patients as defined in their contract with MHC.

Effective July 1, 2012, services provided in an inpatient setting that can be deemed provider preventable must be identified through encounter data submissions and by completing the Medi-Cal PPC Reporting Form DHCS 7107. MHC will screen the encounter data received from network providers for the presence of the Health Care Acquired Conditions and Other Provider Preventable Conditions listed on Form DHCS 7107. Form DHCS 7107 must be completed and sent to MHC upon discovery of the preventable condition as this information will be subject to audit by DHCS. More information regarding this requirement is available APL-15-006 on the DHCS website.

## Procedure

Single encounter (for our purposes) is defined as all services performed by a single Provider/ Practitioner on a single date of service for an individual Member.

The following guidelines are provided to assist our Providers/Practitioners with submission of complete encounter data:

- Reporting of services must be done on a per Member, per visit basis
- A reporting of all services rendered by date must be submitted to MHC
- Encounter Data must reflect same data elements required under a fee-for-service program
- All encounter data reporting is subject to, and must be in full compliance with, the Health Insurance Portability and Accountability Act and any other regulatory reporting requirements

Electronic Encounter Reporting is Subject to the Following Requirements:

- Data must be submitted in the HIPAA compliant 837 format (ASC X12N 837)
- DHCS mandated values must be used when appropriate (e.g., procedure code modifiers)

- Electronic encounter data must be received no later than 60 days from the date of services.
- Only encounter records that pass MHC edits will be included in the records evaluated for compliance.
- Encounters that fail MHC edits will be rejected and responses be supplied back utilizing the standard 999 acknowledgement and 277CA response files
- Rejected encounters must be corrected and resubmitted within 60 days from the date of services to be included in the performance standards
- In no event will incomplete, inaccurate data be accepted

All providers are required submit encounters via EDI and have the ability to submit adjustments, voids/reversal transactions.

If a Clearinghouse is used to process your electronic encounter or claims to MHC, please ensure that your contracted Clearinghouse uses the correct Payer ID for the type of EDI transactions (FFS Claims vs. Encounter):

- FFS claims Payer ID: 38333
- Encounters Payer ID: 33373

### Sanctions

Providers/Practitioners will be sanctioned for noncompliance. These sanctions may include ineligibility from Molina's incentive programs, freezing new enrollment, capitation withhold, and/or ultimately terminating the capitation contract.

## Children's Health and Disability Prevention (CHDP)/EPSDT Submission

The California Department of Health Care Services (DHCS) requires that all Medi-Cal Members zero through their 20th year and 11 months receive periodic health screening exams. Exams performed must meet the requirements of this program utilizing components of the Children's Health and Disability Prevention (CHDP)/Early Periodic Screening Diagnosis and Treatment (EPSDT) services program, a part of Children's Medical Services State Program, the American Academy of Pediatricians (AAP) Periodicity Table for Wellness Exams, and the American Academy of Pediatrician Periodicity and Recommendations for Immunizations.

All Wellness (CHDP/EPSDT) exams for MHC Medi-Cal Members must be documented on an encounter or claim form.

### CHDP/EPSDT Submission to MHC

- Providers must use the standard claim and/or encounters to submit CHDP/EPSDT services

- If a PCP is contracted with an IPA/Medical Group, the PCP should follow their respective IPA/Medical Group's data submission guidelines
- All providers should submit timely claims and/or encounter data through normal and current reporting channels to ensure the receipt of incentive payouts by MHC

### CHDP/EPSDT Incentive Program

Please refer to MHC's P4P Program for details.

# 24. COMPLIANCE

## Oversight and Monitoring

The Medi-Cal Contract between the Department of Health Care Services (DHCS) and Molina Healthcare of California (MHC) defines a number of performance requirements that must be satisfied by both MHC and those Providers/Practitioners and IPA/Medical Groups/Hospitals agreeing, through delegated contractual relationships (or subcontracts), to provide services to eligible and enrolled MHC members. Among these are:

- The Provider/Practitioner's agreement to participate in medical and other audits (e.g. Health Effectiveness Data and Information Set (HEDIS) and/or mandated) conducted by DHCS, other regulatory agencies, or MHC
- The Provider/Practitioner's agreement to maintain books and records for a period of seven years and make such documents available to regulatory agencies and MHC
- The Provider/Practitioner's agreement to furnish MHC with encounter data Providers/Practitioners are encouraged to review their contracts with MHC to become thoroughly familiar with these and additional performance requirements
- The Provider/Practitioner's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor

## Compliance Reporting Requirements for IPAs/Medical Groups/Hospitals

MHC routinely monitors its network of delegated capitated IPAs/Medical Groups/Hospitals for compliance with various standards. These requirements include but are not limited to:

1. MHC requires the delegated capitated IPAs/Medical Groups/Hospitals to submit monthly claims timeliness reports. These reports are due to MHC by the 15th of each month for all claims processed in the previous month. 90 percent of claims are to be processed within 30 calendar days of receipt. 100 percent of all claims are to be processed within 45 working days. Refer to the Claims Section for MHC's claim processing requirements, MHC requires the delegated capitated IPAs/Medical Groups/Hospitals to achieve passing claims audit scores. Claims audits are conducted annually. More frequent audits are conducted when the IPA/Medical Group/Hospital has deficiencies and/or does not achieve the timely processing requirements referenced above
2. Claims Settlement Practices and Dispute Resolution Mechanism
    a. MHC requires IPAs/Medical Groups/Hospitals to submit quarterly claims timeliness reports. These reports are due to MHC on or before the last calendar day of the month after the last month of each calendar quarter

b. The Designated Principal Officer for Claims Settlement Practices must sign the Quarterly Claims Reports
c. MHC also requires IPAs/Medical Groups/Hospitals to submit quarterly Provider Dispute Resolution Reports. These reports are also due on or before the last calendar day of the month after the last month of each calendar quarter
d. The Designated Principal Officer for the Dispute Resolution Mechanism must sign the Quarterly Provider Dispute Resolution Reports
e. These quarterly reports are due as follows:

| Calendar Quarter | Due Date |
|---|---|
| First Quarter | April 30 |
| Second Quarter | July 31 |
| Third Quarter | October 31 |
| Fourth Quarter | January 31 |

f. MHC will conduct an annual PDR audit. More frequent audits will be conducted when the IPA/Medical Group/Hospital does not meet the PDR requirements.

3. Financial Reporting/Viability
a. Quarterly financial statements are due to MHC within 45 calendar days from the end of the IPA's/Medical Group's/Hospital's fiscal quarter. The quarterly financial statements need not be certified by outside auditors but must be accompanied by a financial statement certification form signed by the Chief Financial Officer or President of the IPA/Medical Group/Hospital. Audited annual statements are due within 120 calendar days, but no later than 150 days, from the end of each IPA's/Medical Group's/Hospital's fiscal year. The audited annual statement must include footnote disclosures, and be prepared by an independent Certified Public Accountant in accordance with generally accepted accounting principles (GAAP)

All statements must be submitted on time and meet SB 260 and MHC's viability standards: 1) current assets are greater than current liabilities, and 2) tangible net equity is positive. Quarterly viability cannot be determined if the organization has not submitted their most recent annual audited statement

In accordance with SB 260 (Financial Solvency Reporting), the IPA/Physician Group must also submit a quarterly financial survey report to the Department of Managed Health Care (DMHC) within 45 calendar days from the end of the IPA/Physician Group's fiscal quarter

The IPA/Physician Group must also submit an annual financial survey report to DMHC within 150 calendar days from the end of the IPA/Physician Group's fiscal year

The IPA/Physician Group must also submit a copy to MHC of their DMHC certification and/or financial survey which will show that the quarterly and/or annual survey has been completed on DMHC's web site. In addition, MHC will also review each IPA/Physician Group's cash-to- claims ratio, which is determined based on receivables collectable within 60 days according to the Balance Sheet and Grading Criteria from the DMHC financial survey

4. Utilization Management Reporting
   a. MHC's Delegation Oversight Department is responsible for oversight and monitoring of delegated activities to ensure specific structures and mechanisms are in place to monitor IPA performance and compliance. This includes systematic monitoring of business functions and annual audits of each delegated IPA/Medical Group and Plan Partners, to ensure their ability to perform delegated functions and adherence to all applicable regulatory and accreditation standards
   b. In order to achieve and maintain delegation status for UM activities the delegate must demonstrate the ongoing, and fully functional systems are in place, and meet all the required UM operational standards and reporting requirements
   c. MHC requires capitated/delegated IPA/Medical Groups to submit utilization management reports in accordance with their Utilization Management Delegation Agreement. UM delegated entities that are required to submit reports on an annual, quarterly, and monthly basis. These include but are not limited to:
      - Annually: Delegated IPA/MG are required to submit their UM Program Evaluation (from the prior year), UM Program and UM Workplan (for the current year). The UM Program must include all components required by Accreditation, State, and Federal agencies
      - Quarterly: Updates to the UM Workplan are submitted on a quarterly basis. Results for UM metrics are reported, including key findings and analysis, and planned interventions if goals are not met
      - Monthly: Delegated entities are required to submit a number of logs on a monthly basis. These include, but are not limited to, authorization logs and denial logs. These logs are reviewed by the nursing staff to ensure that requirements are being met; including, but not limited to, mandated turnaround times

MHC conducts its own Quality Improvement (QI) program. The IPA/Medical Groups and Providers/ Practitioners agree to abide by and participate in MHC's QI program.

## Quality Oversight Monitoring

Under the terms of its contract with DHCS, MHC conducts ongoing reviews of Provider/Practitioner performance. Among the elements to be reviewed are the following:

- Conducts an annual or more frequent geo-access audit to determine geographic, PCP and Specialist gaps in the network. The data provides information for contracting strategies
- MHC also conducts at least annual cultural, ethnic, racial and linguistic geo-access survey to assess availability of practitioners to meet the member's needs and determine network gaps. The data provides information for contracting strategies
- MHC conducts an annual telephonic survey to review the time it takes members to access emergency care, urgent care, non-urgent (routine) care, specialty care, initial health assessments, first prenatal visits, physical exams, and wellness checks in accordance with access standards disclosed in Section 5, Access to Care

Member Complaint and Grievance Indicators - Member concerns specific to the care and services of specific Providers/Practitioners are collected and acted upon by MHC's Member Services Department.

Providers/Practitioners are engaged in the review of specific concerns and will be asked to assist in remedial endeavors, as indicated.

The outcomes and findings of the foregoing and other performance indicators are reviewed by MHC's Quality Improvement Department and by MHC's Quality Improvement Committee.

## Quality Improvement Corrective Action Plans

When it is found that Providers/Practitioners or IPAs/Medical Groups do not meet the terms of their contracts, applicable policies and procedures, licensing and related requirements, and the provisions of this Manual, they will be notified in writing of deficiencies. Quality Improvement Corrective Action Plans (CAP) will be forwarded to Providers/Practitioners and will include corrective actions and dates by which corrective actions are to be achieved.

MHC representatives will work with and offer support to Providers/Practitioners to ensure the timely resolution of CAP requirements.

Providers/Practitioners who fail to respond to an initial corrective action plan by the date specified will be provided a second iteration of CAP requirements; may be assigned an extended action plan due date and/or sign a document stating they have completed the CAP.

## Non-Compliance with Quality Improvement Corrective Actions

MHC's Quality Improvement and/or Provider Services Departments coordinates and assists the Provider/Practitioner with the development and implementation of the corrective action plan. Non-compliance with Quality Improvement corrective actions may result in any of the following:

- Contact by the MHC's Quality Improvement Department
- Conduct in-service/education

- Referral to the IPA or Medical Group for corrective action
- Implementation of Provider/Practitioner Compliance Department corrective action program which may result in the following sanctions:
  - The termination of new member enrollments
  - Moving current members to another IPA/Medical Group where the Provider/Practitioner is affiliated
  - Formal contract termination

## Re-Audits

Re-audits are conducted to assure corrective actions have been effective in improving compliance with previously identified deficiencies.

## Delegated IPAs and Medical Groups

MHC does not delegate any Quality Improvement Activities to any contracted Provider/Practitioner or IPA/Medical Group organization.

## Oversight Monitoring of Utilization Management and Credentialing Programs for Delegated Providers

MHC may delegate responsibility for activities associated with utilization management (UM) and credentialing, to its IPAs/Medical Groups. Prior to approval of delegation, and at least annually thereafter, MHC conducts an onsite review of IPAs/Medical Groups requesting delegation. MHC uses delegation standards in compliance with NCQA, State and Federal Requirements. A member or designee of the delegation oversight team assigned to evaluate and oversee the IPAs/Medical Groups activities conducts the evaluation. Based on the audit scores and findings, if required thresholds and criteria are met, the appropriate peer review Committee may grant specific delegation functions to the IPA/Medical Group to perform. If approved for delegation “Acknowledgement Acceptance of Delegation” must be signed between MHC and the IPA/Medical Group. A “Delineation of Utilization Management Responsibilities” grid is included with the Acknowledgement and Acceptance of Delegation”, outlining the delegated activities; MHC’s Responsibilities; the Delegated IPA/Medical Group Responsibilities; the Frequency of Reporting; MHC’s Process for Evaluating Performance; and Corrective Actions if the IPA/Medical Group fails to meet responsibilities.

MHC reserves the right to request corrective action plans or revoke the delegation of these responsibilities when the Delegated group demonstrates noncompliance to NCQA State and Federal Requirements.

Complex Case Management services are not delegated to IPAs/Medical Groups. MHC’s Medical Case Management Department retains sole responsibility for authorization and implementation of these services. IPAs/Medical Groups are required to refer known or potential cases to MHC Case Management. The referral may be made by telephone or facsimile. This information can also be found in the Medical Management Section and in the Public Health Coordination and Case Management.

# 25. COMPLIANCE: PROVIDER EDUCATION

Provider education is implemented by Molina Healthcare of California (MHC) and its participating Medical Groups/Independent Physician Associations (IPAs) in counties where it is applicable. Goals, objectives, curricula, and implementation guidelines are established by MHC. Where applicable, participating Medical Groups/IPAs are responsible for conducting provider training and orientation, and MHC provides additional resources and opportunities to supplement such trainings.

All newly contracted providers are required to receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the contract and all applicable Federal and State statutes and regulations. MHC and applicable Medical Group/IPA are required to conduct training for all providers within ten (10) working days after the newly contracted provider is placed on active status. Provider training includes but is not limited to:

- Provider/Practitioner Manual (MHC and/or Health Net for LA County only)
- Federal and State statutes and regulations to ensure provider's full compliance and applicable policies and procedures
- Web Portal Training
- Prior Authorization
- Preventive Care Services
- Training on provider billing and reporting, including information prohibiting balance billing
- Encounters, claims submission, appeals and grievances, and compensation information
- Disability Awareness and Sensitivity Training regarding SPDs based on "Clinical Protocols and Practice Guidelines for Seniors and Persons with Disabilities/Chronic Conditions"
    - Providers will be trained on a continual basis regarding clinical protocols and evidenced-based practice guidelines for SPDs or chronic conditions. The training shall include an educational program for providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, information on MHC's website as well as other methods of educational outreach to providers
- Fraud, Waste, and Abuse
- Concepts in cultural competency. Training will discuss the practical applications of cultural competency, review cultural and linguistic contract requirements, discuss Molina's language access services and tips for working with interpreters, and go over cultural competency resources
    - Providers/Practitioners are trained on how to promote access and delivery of services in a culturally competent manner to all members. This includes those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. Providers/Practitioners must ensure that members have access to covered services that are delivered in a manner that meets their unique needs. For more

information on promoting access and delivery of services in a culturally competent manner, please refer to the “Cultural and Linguistic Services” section of the manual

- Model of Care, Coordination of Care, Behavioral Health services, LTSS, community supports and other Medicare Medicaid Plan/Cal MediConnect program requirements and ensure access is provided
- LTSS, including but not limited to, Community Based Adult Services, In Home Supportive Services, Multi- Purpose Senior Services Program and Skilled nursing facility/subacute care services. Training will include information about how to identify LTSS needs, eligibility criteria, and how to appropriately refer for LTSS services
- Distribution of Members Rights and Responsibilities, including the right to full disclosure of health care information and the right to actively participate in health care decisions

MHC and applicable Medical Group/IPA are required to ensure ongoing training is conducted when deemed necessary.

## Membership Panel Form

All IPAs and direct providers are required to notify MHC of changes made to Membership Panels within five business days. Timely submission of this information is vital for maintaining an up-to-date provider directory and allows our members to accurately identify which providers, in our network, are accepting new patients. The Membership Panel Form enables IPAs and direct providers to feasibly modify their membership panels and inform MHC of those modifications.

IPAs and direct providers are requested to submit the Membership Panel form on the next page within five business days when there is a change in regard to accepting new members. Providers affiliated to IPAs should submit the required information directly to their IPAs as appropriate. If a provider who is not accepting new members is contacted by a member or someone seeking to become a new member, the provider shall direct the member or potential member to MHC for additional assistance in finding a provider and to the Department of Managed Health Care to report any inaccuracy with the plan’s directory.

### PCP Termination and Member Reassignment Policy

The guidelines outlined in this policy are intended to retain the accuracy of our network while keeping the Members care as a priority.  Scenarios outside of this policy will be researched and decisions will be made in the best interest of the member.

**Directly Contracted PCPs**

| Scenario | Action |
|---|---|
| Terming PCP practices under a group contract | Members will remain with the Group |
| Terming PCP practices under a solo contract | Member will be assigned within the Network |

**IPA's/ Medical Groups**

| Scenario | Action |
|---|---|
| Terming PCP practices in a Federally Qualified Health Center (FQHC) | Member will remain with the FQHC |
| Federally Qualified Health Center (FQHC) is moving from one IPA to another | Member will remain with the FQHC |
| Terming PCP is a solo practitioner and is affiliated with multiple IPA | Member will remain with the PCP and be transitioned to the still contracting IPA to ensure members continuity of care. |
| If PCP is being admiratively terminated by Molina or the IPA for such reasons as malpractice insurance, suspension of license, or failure to pass Facility Site Review | Member will remain with the IPA |
| If an IPA wishes to have members reassigned to PCPs within the IPA at time of provider termination, The IPA must make those assignments know at the time of notice. | Molina will make every effort to accommodate the request subject the Members right to choose their PCP. |

| | | | | |
|---|---|---|---|---|
| Provider Name | | | | |
| NPI | | | | |
| Street Address | | | | |
| City, State, Zip Code | | | | |
| Phone Number | | | | |
| IPA Affiliation/Group Name and/or Pay to Affiliation | ☐ Medi-Cal | ☐ Covered CA/ Marketplace | ☐ Medicare | ☐ Cal Medi-Connect |
| Accepting New Members? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | | | |

Please email or fax the completed form to one of the appropriate locations listed below. For providers affiliated with IPAs, please submit the required information directly to your IPA, who will submit the information to MHC.

San Diego County: MHCSanDiegoProviderServices@MolinaHealthCare.Com

LA/OC Counties: MHC_LAProviderServices@MolinaHealthCare.Com

Inland Empire County: MHCIEProviderServices@MolinaHealthCare.Com

Imperial County: MHCImperialProviderServices@MolinaHealthCare.Com

Sacramento County: MHCSacramentoProviderServices@MolinaHealthCare.Com

Name of individual completing this form: _____

Signature of individual completing this form: _____

Phone Number: _____

Date: _____/_____/_____

If you have any questions or concerns, please contact your Provider Services Representative.

# 26. COMPLIANCE: QUALITY IMPROVEMENT

## Quality Improvement Program

### Purpose

The purpose of the Molina Healthcare of California (MHC) Quality Improvement Program is to establish methods for objectively and systematically evaluating and improving the quality of care and service provided to MHC members. MHC strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The MHC's Quality Improvement Program promotes a commitment to quality in every facet of the health plan's structure and processes. It relies on senior management oversight and accountability and integrates the activities of all health plan departments in meeting the program's goals and objectives. The Quality Improvement Program involves all key stakeholders, members, participating practitioners, providers and health plan staff, in the development, evaluation and planning of quality improvement activities.

The MHC's Quality Improvement Program incorporates a continuous, quality improvement methodology that focuses on the specific needs of its internal and external customers. It is organized to identify and analyze significant opportunities for improvement in delivery of health care and service, to develop improvement strategies, and to track systematically, if these strategies result in progress toward benchmarks or goals. The methodology includes pursuing our goals in a culturally competent manner.

The written Quality Improvement Program defines the goals, objectives, scope, structure, committees and functions of the program. The Quality Improvement Program is reviewed and updated annually and presented to the Quality Improvement Committee (QI Committee) and to the Board of Directors for approval.

### Scope of the Quality Improvement Program

The MHC Quality Improvement Program encompasses the quality of acute, chronic, and preventive clinical care and service provided in both the inpatient and outpatient setting by hospitals and facilities, participating provider groups, primary care and specialty practitioners, and ancillary providers.

Its specific focus includes:

1. The continuity and coordination of care
2. The over-and-under-utilization of services
3. The access to and availability of routine, urgent and, emergency care
4. The health status of MHC members of all products
5. Provider and practitioner qualifications and performance
6. The environmental, physical, and clinical safety of MHC members
7. The implementation of preventive health and clinical practice guidelines
8. Member and practitioner satisfaction

9. The effectiveness of health plan services including member education and services, practitioner relations and services, credentialing, utilization and case management, claims adjudication, risk management, and pharmacy management
10. The ethnic and linguistic appropriateness of care and service
11. Behavioral health services as defined by DHCS
12. Assessing the effectiveness of quality improvement activities

## Provider/Practitioner Review Process

### Provider/Practitioner Facility Site Review (FSR)

- Effective July 1, 2002, the State of California's Health and Human Services Agency mandated that all County Organized Health Systems (COHS), Geographic Managed Care (GMC) Plans, Primary Care Case Management (PCCM) Plans, and Two-Plan Model Plans use the Full Scope Facility Site Review and Medical Record Review Evaluation Tool.
- All primary care sites serving Medi-Cal managed care members must undergo an initial site review and subsequent periodic site review every three years using the current DHCS approved facility site review survey tool. Managed care health plans may review sites more frequently per local collaborative decision or when determined necessary, based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues.
- The Medi-Cal managed care health plans within the county have established systems and procedures for the coordination and consolidation of site audits for mutually shared PCP sites and facilities to avoid duplication and overlapping of FSR reviews.
- All Primary Care Physicians must maintain an Exempted or Conditional pass on site review to participate in MHC provider network. The evaluation scores are based on standardized scoring mechanism established by DHCS. Please refer to the Credentialing section of the Provider Manual for expanded information about FSR requirements.

- For more details on FSR, please reference the Credentialing: Site Review Program Section of this Provider Manual.

### Medical Record Review (MRR)

- The on-site practitioner/provider medical record review is a comprehensive evaluation of the medical records. MHC will provide information, suggestions and recommendations to assist practitioners/providers in achieving the standards.
- All PCPs must complete and pass the medical record review at each practice location. Medical Record Reviews are conducted in conjunction with the Facility Site Review, prior to participating in MHC provider network and at least every three years thereafter.
- All Primary Care Physicians must maintain an Exempted or Conditional pass on medical record review to participate in MHC provider network. The evaluation scores are based on standardized scoring mechanism established by DHCS.

- For more details on MRR, please reference the Credentialing: Site Review Program Section of this Provider Manual.

### Physical Accessibility Review Survey (PARS)

- In accordance with the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) policy letter 12-006, managed care health plans are required to assess the level of physical accessibility of provider sites, including all primary care physicians, specialists and ancillary providers that serve a high volume of Seniors and Persons with Disabilities (SPD). The Physical Accessibility Review Survey (PARS) tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA).
- Unlike the Facility Site Review and Medical Records Review, PARS is a survey, and no corrective action is required.
- For more details on PARS, please reference the Credentialing: Site Review Program Section of this Provider Manual.

### Child Health and Disability Prevention (CHDP)/EPSDT Reviews

- CHDP/EPSDT is a state preventive service program that delivers periodic health assessments and services to low-income children and youth in California. CHDP/EPSDT provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services
- MHC provides health assessment, preventive health care and coordination of care to eligible Members through the CHDP/EPSDT program
- CHDP/EPSDT specific questions are incorporated into the Medical Record Review Tool. The CHDP/EPSDT review may be done concurrently with the medical record review
- CHDP/EPSDT requirements are detailed in the Medical Record Pediatric Review Guidelines

### Comprehensive Perinatal Services Program (CPSP) Review

- The CPSP is designed to increase access to prenatal care and to improve pregnancy outcomes. The services of this program include health and nutrition education, psychosocial assessment, treatment planning, and periodic reassessment. CPSP must be offered to all MHC Medi-Cal Members, but participation is voluntary. Refusal of CPSP must be documented in the patient's obstetrical record

# 27. COMPLIANCE: FRAUD, WASTE, AND ABUSE

## 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, the Compliance department maintains a comprehensive plan, which addresses how Molina will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste, and abuse prevention, detection, and correction 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 prevent, detect, and correct 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

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives to detect, prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

### Regulatory Requirements

### Federal False Claims Act

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

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

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

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double billing for items or services,

submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

### Deficit Reduction Act

The 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 Medicaid payments until compliance is met. Molina Healthcare will take steps to monitor Molina Healthcare of California contracted providers to ensure compliance with the law.

### Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute ("AKS") is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

Molina conducts all business in compliance with Federal and State Anti-Kickback Statutes (AKB) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

**What is AKB?**

AKB statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. **Examples** of prohibited AKB actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under **Molina's policies**, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of Federal health care program business. Providers must not, directly, or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

**Marketing Guidelines and Requirements**

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both State and Federal.

Under **Molina's policies**, Marketing means any communication, to a beneficiary who is not enrolled with Molina, that can reasonably be interpreted as intended to influence the beneficiary to enroll with Molina's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another Health Plan's products.

Restricted marketing activities vary from state-to-state but generally relate to the types and form of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

## Stark Statute

Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to Medicare and Medicaid services provided only by physicians, rather than by all health care 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:** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)

**Waste:** means 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 State and Federal health care programs.

**Abuse:** means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to 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 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 the following:

- A physician knowingly and willfully referring a Member to health care facilities in which or with which the physician has a financial relationship. (Stark Law)
- Altering claims and/or medical record documentation in order to get a higher level of reimbursement
- Balance billing a Molina Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees
- Billing and providing for services to Members that are not medically necessary
- Billing for services, procedures and/or supplies that have not been rendered
- Billing under an invalid place of service in order to receive or maximize reimbursement
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider

- Concealing a Member's misuse of a Molina identification card
- Failing to report a Member's forgery or alteration of a prescription or other medical document
- False coding in order to receive or maximize reimbursement
- Inappropriate billing of modifiers in order to receive or maximize reimbursement
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients
- Not following incident to billing guidelines in order to receive or maximize reimbursement
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges
- Questionable prescribing practices
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code
- Underutilization, which means failing to provide services that are Medically Necessary
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more
- Using the adjustment payment process to generate fraudulent payments

### Examples of Fraud, Waste, and Abuse by a Member

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

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

### Review of Provider Claims and Claims System

Molina Claims Examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

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

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

## Prepayment Fraud, Waste, and Abuse Detection Activities

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

Molina has a pre-payment 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 and 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 Medical Medically Unlikely Edit table, the Medicaid National Correct Coding Initiative (NCCI) files 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 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 in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in

Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

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

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

## Claim Auditing

Molina shall use established industry Claims adjudication and/or clinical practices, Commonwealth, 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 our 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 gives an estimate of the proportion of claims that we 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 Molina, or our Molina's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

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.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, we Molina 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.

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

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

You may also report cases of fraud, waste or abuse to Molina's Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of California
Attn: Compliance
200 Oceangate, Suite 100
Long Beach, CA 90802

Remember to include the following information when reporting:

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

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

California Department of Health Care Services
Medi-Cal Fraud Complaint – Intake Unit
Audits and Investigations
P.O. Box 997413, MS 2500
Sacramento, CA 95899-7413

Toll Free Phone: (800) 822-6222

# 28. COMPLIANCE: PRIVACY REQUIREMENTS & INFORMATION

## HIPAA Requirements and Information

## HIPAA (The Health Insurance Portability and Accountability Act)

### Molina's Commitment to Patient Privacy

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

### Provider Responsibilities

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

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under State and Federal Law, including:

- 42 C.F.R. Part 2 Regulations
- Health Information Technology for Economic and Clinical Health Act, ("HITECH Act")

### Applicable Laws

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

1. **Federal Laws and Regulations**
    - HIPAA
    - The Health Information Technology for Economic and Clinical Health Act (HITECH)
    - 42 C.F.R. Part 2
    - Medicare and Medicaid laws
    - The Affordable Care Act

## 2. State Medical Privacy Laws and Regulations

Providers should be aware that HIPAA provides a floor for patient privacy, but that State Laws, including the California Confidentiality of Medical Information Act (California Civil Code, Division 1, Part 2.6), should be followed in certain situations, especially if the State Law is more stringent than HIPAA and if permitted by such federal law. Providers should consult with their own legal counsel to address their specific situation. The California Confidentiality of Medical Information Act includes a requirement that permits Molina Members to request confidential communications. Providers should ensure that that they comply with the applicable requirements of the California Confidentiality of Medical Information Act.

### 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 treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2]".

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered 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.

[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

## Confidentiality of Substance Use Disorder Patient Records

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

## Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

## Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State law.

## 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 healthcare 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 healthcare Provider/Practitioner 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 healthcare operations or made prior to April 14, 2003.

## HIPAA Security

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

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

## HIPAA Transactions and Code Sets

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

- Claims and encounters

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

Molina 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 tab 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.

### National Provider Identifier (NPI)

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 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

## Business Continuity Plan (BCP)

The Provider will have a documented Business Continuity Plan (BCP) to ensure continuation and recovery of services after a disruption occurs. The BCP will be updated at least annually and approved by the applicable designated representative.

The Provider Business Continuity Plan will include:

- Names and contact information for staff responsible for invoking and managing response and recovery
- Molina notification names and contact information
- Disaster declaration process
- Details of how the services will be recovered and restored
- Details of how the systems and applications supporting the services will be recovered and restored, including recovery of data

The Provider will notify Molina of a disruption to the services or activation of business continuity plans within two hours of occurrence and will provide Molina with regular updates on the situation and actions taken to resolve the issue, until normal services have been resumed.

The Provider will ensure that its third parties needed to deliver the services have appropriate Business Continuity Plans in place to prevent significant disruption to the services.

The Provider will test the BCP at least annually and document the test results. Provider will make available to Molina, upon request, the results of the most recent test including lessons learned and remediation plans.

The Provider will participate in Molina annual tests upon notification and mutual agreement.

After disruption to services, once normal service has been resumed, the Provider will promptly complete a root cause analysis report and provide it to Molina.

## Definitions

**Business Continuity Plan:** documented procedures that guide organizations to respond, recover, resume and restore to a pre-defined level of operations following a disruption.

**Disaster Recovery Plan**: a document that defines the resources, actions, tasks and data required to manage the technology recovery effort.

**Disaster Declaration**: criteria to declare a disaster and the staff authorized to invoke recovery plans to recover and restore Services.

## Cybersecurity Requirements

Note: This section (Cybersecurity Requirements) is only applicable to providers who are delegated providers and have been delegated by Molina to perform a health plan function.

1. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by law or any enforcement agency.
2. The following terms are defined as follows:
    - I. "Consumer" means an individual who is a State resident, whose Nonpublic Information is in Molina's possession, custody or control and which Provider maintains, processes, stores or otherwise has access to such Nonpublic Information.
    - II. "Cybersecurity Event" means any act or attempt, successful or, to the extent known by Provider, unsuccessful, to gain unauthorized access to, disrupt or misuse an Information System or Nonpublic Information stored on such Information System. The ongoing existence and occurrence of attempted but Unsuccessful Security Incidents shall not constitute a Cybersecurity Event under this definition. "Unsuccessful Security Incidents" are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Molina Nonpublic Information or sustained interruption of service obligations to Molina.
    - III. "Information System" or "Information Systems" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic Nonpublic Information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.
    - IV. "Nonpublic Information" means information that is not publicly available information and is one of the following:
        - (a) business related information of Molina the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Molina;
        - (b) any information concerning a Consumer that because of the name, number, personal mark, or other identifier contained in the information can be used to identify such Consumer, in combination with any one or more of the following data elements:
            - (i) social security number;

(ii) driver's license number, commercial driver's license or state identification card number;
(iii) account number, credit or debit card number;
(iv) security code, access code, or password that would permit access to a Consumer's financial account; or
(v) biometric records;

(c) any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a Consumer, that can be used to identify a particular Consumer, and that relates to any of the following:
(i) the past, present, or future physical, mental or behavioral health or condition of a Consumer or a member of the Consumer's family;
(ii) the provision of health care to a Consumer; or
(iii) payment for the provision of health care to a Consumer.

V. "State" means the State of California.

3. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information, as defined herein, that are accessible to, or held by, the Provider. Implementation of the foregoing measures shall incorporate guidance issued by the State Department of Insurance, as appropriate.
4. Provider agrees to comply with all applicable laws governing Cybersecurity Events. Molina will decide on notification to affected Consumers or government entities, except where Provider is solely responsible and required to notify such Consumers or government entities by Law. Upon Molina's prior written request, Provider agrees to assume responsibility for informing all such Consumers in accordance with applicable Law.

In the event of a Cybersecurity Event, Provider shall notify Molina's Chief Information Security Officer of such Cybersecurity Event by telephone and email (as provided below) as promptly as possible, but in no event later than 24 hours from a determination that a Cybersecurity Event has occurred. In addition to the foregoing, Provider shall notify Molina's Chief Information Security Officer (by telephone and email) within 24 hours following payment of a ransom that involves or may involve Molina Nonpublic Information.

Notification to Molina's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer
Telephone: (844) 821-1942
Email: CyberIncidentReporting@molinahealthcare.com

A follow-up notification shall be provided by mail, at the address indicated below.

Molina Chief Information Security Officer
Molina Healthcare of California
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

5. Upon Provider's notification to Molina of a determination of a Cybersecurity Event, Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation, or, upon written request by Molina, Provider shall complete an investigation pursuant to the following requirements:
   (a) determine whether a Cybersecurity Event occurred;
   (b) assess the nature and scope of the Cybersecurity Event;
   (c) identify Nonpublic Information that may have been involved in the Cybersecurity Event; and
   (d) perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of the Nonpublic Information.
6. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon request of Molina.
7. Provider must provide to Molina the following information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina in the initial and subsequent notices must include as much of following information known to Provider at the time of the notification:
   (a) the date of the Cybersecurity Event;
   (b) a description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Provider, if any;
   (c) how the Cybersecurity Event was discovered;
   (d) whether any lost, stolen, or breached information has been recovered and if so, how this was done;
   (e) the identity of the source of the Cybersecurity Event;
   (f) whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
   (g) a description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the Consumer;
   (h) the period during which the Information System was compromised by the Cybersecurity Event;
   (i) the number of total Consumers in the State affected by the Cybersecurity Event;
   (j) the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;

(k) a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
(l) a copy of Provider's privacy policy and if requested by Molina, the steps that Provider will take to notify Consumers affected by the Cybersecurity Event; and
(m) the name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

1. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments.

In the event provisions of this Section conflict with provisions of any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

## Business Contact Information

If you are a California resident, you may have certain rights with respect to the business contact personal information that you provide to Molina as a Provider, pursuant to the California Privacy Rights Act ("CPRA"), which amends the California Consumer Privacy Act ("CCPA"). For more information about those rights and how they may be exercised, please see the "California Residents" section of Molina's Website Privacy Policy, available at https://www.molinahealthcare.com/members/common/en-US/terms_privacy/ca.aspx.

## Your Privacy

Dear Molina Healthcare of California Partner Plan, (Molina Healthcare) Member:

Your privacy is important to us. We respect and protect your privacy. Molina Healthcare uses and shares your information to provide you with health benefits. Molina Healthcare wants to let you know how your information is used or shared.

## Your Protected Health Information

Does Molina Healthcare use or share our members' PHI?

- To provide for your treatment
- To pay for your health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To use or share PHI for other purposes as required or permitted by law.

Does Molina Healthcare need your written authorization (approval) to use or share your PHI?

Molina Healthcare needs your written approval to use or share your PHI for purposes not listed

## What are your privacy rights?

- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have given your PHI

## How does Molina Healthcare protect your PHI?

Molina Healthcare uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways Molina Healthcare protects PHI:

- Molina Healthcare has policies and rules to protect PHI
- Molina Healthcare limits who may see PHI. Only Molina Healthcare staff with a need-to-know PHI may use it
- Molina Healthcare staff is trained on how to protect and secure PHI

- Molina Healthcare staff must agree in writing to follow the rules and policies that protect, and secure PHI Molina Healthcare secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords

Our Notice of Privacy Practices has more information about how we use and share our members' PHI. Our Notice of Privacy is in the following section and is on our web site at: www.MolinaHealthcare.com. You may also get a copy of our Notice of Privacy by calling our Member Services Department at (888) 665-4681.

## NOTICE OF PRIVACY PRACTICES

## MOLINA HEALTHCARE OF CALIFORNIA PARTNER PLAN

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

California Partner Plan, ("Molina" or "we") provides health care benefits to you through the Medi-Cal program. Molina uses and shares protected health information about you to provide your health care benefits. We use and share your information to carry out treatment, payment and health care operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private. We have policies in place to obey the law. The effective date of this notice is March 1, 2013.

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

### Why does Molina use or share your PHI?

We use or share your PHI to provide you with healthcare benefits. Your PHI is used or shared for treatment, payment, and health care operations.

### For Treatment

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

### Payment

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

### For Health Care Operations

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

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

- Improving quality
- Actions in health programs to help members with certain conditions (such as asthma)
- Conducting or arranging for medical review
- Fraud and abuse programs
- Actions to help us obey laws
- Address member needs, including solving complaints and grievances

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

When can MHC use or share your PHI without getting written authorization (approval) from you?

The law allows or requires MHC to use and share your PHI for several other purposes including:

### Required by law

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

### Public Health

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

### Health Care Oversight

Your PHI may be used or shared with government agencies. They may need your PHI to check how our health plan is providing services.

### Legal or Administrative Proceedings

Your PHI may be shared with a court, investigator or lawyer if it is about the operation of Medi-Cal. This may involve fraud or actions to recover money from others, when the Medi-Cal program has provided your health care benefits.

### When does MHC need your written authorization (approval) to use or share your PHI?

MHC needs your written approval to use or share your PHI for purposes other than those listed in this notice. You may cancel a written approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

### What are your health information rights?

You have the right to:

- Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)

  You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to make your request in writing. You may use Molina's form to make your request

- Request Confidential Communications of PHI

  You may ask MHC to give you your PHI in a certain way or at a certain place to help keep your PHI private. We will follow reasonable requests, if you tell us how sharing all or a part of that PHI could put your life at risk. You will need to make your request in writing. You may use MHC's form to make your request

- Review and Copy Your PHI

  You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions as a MHC member. You will need to make your request in writing. You may use MHC's form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases, we may deny the request

  Important Note: We do not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.

- Amend Your PHI

  You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a member. You will need to make your request in writing. You may use MHC's form to make your request. You may file a letter disagreeing with us if we deny the request.

- Receive an Accounting of PHI Disclosures (Sharing of your PHI)

  You may ask that we give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:

  - for treatment, payment or health care operations;
  - to persons about their own PHI;
  - sharing done with your authorization;
  - incident to a use or disclosure otherwise permitted or required under applicable law;
  - as part of a limited data set in accordance with applicable law; or shared prior to April 14, 2003

We will charge a reasonable fee for each list if you ask for this list more than once in a 12-month period. You will need to make your request in writing. You may use MHC's form to make your request. You may make any of the requests listed above or may get a paper copy of this Notice. Please call our Director of Member Services at 1-888-665-4621.

## Do I Complain?

If you believe that we have not protected your privacy and wish to complain, you may file a complaint (or grievance) by calling or writing us at:

Molina Healthcare of California Partner Plan, Member Services (888) 665-4621

We will not do anything against you for filing a complaint. Your care will not change in any way.

OR you may call, write or contact the agencies below:

Privacy Officer
c/o: Office of Legal Services
California Department of Health Care Services
P.O. Box 997413, MS 0011
Sacramento, CA 95899-7413
(916) 440-7700
Email: privacyofficer@dhcs.ca.gov

Secretary of the U.S. Department of Health and Human Services
Office for Civil Rights
U.S. Department of Health & Human Services
50 United Nations Plaza - Room 322
San Francisco, CA 94102

(415) 437-8310; (415) 437-8311 (TDD); (415) 437-8329 FAX

### What are the duties of Molina?

MHC is required to:

- Keep your PHI private.
- Give you written information such as this on our duties and privacy practices about your PHI.
- Follow the terms of this Notice

This Notice is Subject to Change - Changing information practices and terms of this notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, a new notice will be sent to you by US Mail.

If you have any questions, please contact the following:

Member Services
Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (888) 665-4621

# 29. CREDENTIALING: SITE REVIEW PROGRAM

The Site Review Program is a comprehensive evaluation of the facility, administration and medical records to ensure conformance to the California Department of Health Care Services (DHCS) and regulatory agency standards. The review and certification of Primary Care Practitioner (PCP) sites are required for all health plans participating in the Medi-Cal managed care program (Title 22, CCR, Section 56230). The California statute requires that all PCP sites or facilities rendering services to Medi-Cal eligible patients must be certified and compliant with all applicable DHCS standards. Furthermore, site reviews, including the Facility Site Review (FSR) and Medical Record Review (MRR) are required as part of the credentialing process, according to the provision of Title 22, CCR, Section 53856.

A PCP is defined as a General Practitioner, an Internist, a Family Practitioner, Obstetrician/Gynecologist (OB/GYN) who meets the requirements for PCP, or a Pediatrician who, by contract, agrees to accept responsibility for primary medical care services.

## Facility Site Review Process

Effective July 1, 2002, the State of California's Health and Human Services Agency mandated that all County Organized Health Systems (COHS), Geographic Managed Care (GMC) Plans, Primary Care Case Management (PCCM) Plans, and Two-Plan Model Plans use the Full Scope Facility Site Review and Medical Record Review Evaluation Tool.

In efforts to avoid duplication and overlapping of Site Reviews, the Medi-Cal managed care health plans within the county have established systems and procedures for the coordination and consolidation of site audits for mutually shared PCP sites and facilities. Site reviews conducted by a participating collaborative Medi- Cal managed care health plan will be accepted by other Medi-Cal managed care health plans. This will establish ONE certified FSR and MRR that the participating PCP site will need to pass and be eligible with all the Medi-Cal Health Plans in a given county.

Standardized DHCS Site Review Tools are comprised of three components:

- Facility Site Review Tool
- Medical Record Review Tool
- Physical Accessibility Review Survey

## Initial Full Scope Review

All primary care sites serving Medi-Cal managed care members must undergo an initial facility site review with attainment of a minimum passing score of eighty percent (80%) on the site review and correction of all findings. The initial facility site review is the first onsite inspection of a site that has not previously had a full scope survey, or a PCP site that is returning to the Medi-Cal managed care program and has not had a full scope

survey within the past three years with a passing score. The initial facility site review survey can be waived by a managed care health plan for a pre-contracted physician site if the physician has a documented proof of current full scope survey, conducted by another Medi-Cal managed care health plan within the past three years. MHC follows the same procedures as for an initial site visit when a PCP relocates or opens a new site. An initial medical record review will be completed within three to six months after membership is assigned to the PCP.

## Subsequent Periodic Full Scope Site Review

After the initial full scope survey, the maximum time period before conducting the subsequent full scope site survey is three years. Managed care health plans may review sites more frequently per local collaborative decision or when determined necessary, based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues.

## Medical Record Review

The on-site practitioner/provider medical record review is a comprehensive evaluation of the medical records. Molina Healthcare of California (MHC) will provide information, suggestions and recommendations to assist practitioners/providers in achieving the standards. Medical records reviews must be completed for each PCP site. Medical Record Reviews are conducted initially and at least every three years thereafter, in conjunction with the facility site review. Ten (10) medical records are reviewed for each physician. Sites where documentation of patient care by multiple PCPs occurs in the same medical record will be reviewed as a "shared" medical record system. Shared medical records are those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of 10 records will be reviewed if two to three PCPs share records, 20 records will be reviewed for four to six PCPs, and 30 records will be reviewed for seven or more PCPs. Site Reviewers have the option to request additional medical records to ensure adequate review of all provider specialties, member populations, etc. If additional records are reviewed, scores will be calculated accordingly.

## Physical Accessibility Review Survey (PARS)

In accordance with the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) policy letter 12-006, managed care health plans are required to assess the level of physical accessibility of provider sites, including all primary care physicians, specialists, ancillary providers and Community-Based Adult Services (CBAS) that serve a high volume of Seniors and Persons with Disabilities (SPD). The PARS tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA). PARS consist of established criteria that include critical access elements. Based on the outcome of the PARS review, each site is designated as having either Basic Access or Limited Access, and medical equipment access. Basic Access demonstrates that a facility site provides access for members with disabilities to parking, exterior building, interior building, waiting/reception, restrooms, and examination rooms.

Unlike the Facility Site Review and Medical Records Review, PARS is an assessment, and no corrective action is required and is not a credentialing requirement.

## Scoring

All Primary Care Physicians must maintain an Exempted or Conditional pass on site review and medical record review to participate in MHC provider network. The evaluation scores are based on standardized scoring mechanism established by DHCS.

## Compliance & Corrective Action Plan (CAP)

### Facility Site Review Score Threshold

Exempted: A performance score of 90 percent or above without deficiencies in Critical Elements (CE), Pharmaceutical or Infection Control sections of the review tool.

A Corrective Action Plan is not required.

Conditional: A performance score of 80 to 89 percent or 90 percent and above with deficiencies in Critical Elements, Pharmaceutical and/or Infection Control sections of the review tool.

A Corrective Action Plan is required.

Fail: Below 80 percent performance score.

A Corrective Action Plan is required.

The PCP may be administratively terminated/removed from the MHC network.

### Medical Record Review Score Threshold

Exempted: A performance score of 90 to 100 percent; with all section scores at 80 percent and above.

A Corrective Action Plan is not required

Conditional: A performance score of 80 to 89 percent or 90 percent and above, with one or more section scores below 80 percent

A Corrective Action Plan is required.

Fail: Below 80 percent performance score.

A Corrective Action Plan is required

The PCP may be administratively terminated/removed from the MHC network.

### Physicians with an Exempted Pass Score

All reviewed sites that score 90 to 100 percent on the facility site review survey without deficiencies in Critical Elements, Pharmaceutical and/or Infection Control sections of the review tool do not need to submit a CAP.

All reviewed sites that score 90 to 100 percent and greater than 80 percent on each section scores of the medical record review survey do not need to submit a CAP.

### Physicians with a Conditional Pass Score

A score of 80 to 89 percent or 90 percent and above with deficiencies in Critical Element, Pharmaceutical and/or Infection Control sections of the review tool must complete and submit a CAP.

- Critical Element CAP must be completed and submitted within 10 business days from the date of the review
- CAP for non-critical elements must be completed and submitted within 30 calendar days from the date of the written CAP request

A score of 80 to 89 percent of the medical record review survey must complete and submit a CAP. Any section score of less than 80 percent in the medical record review survey requires submission of completed CAP, regardless of the aggregated MRR score.

- The MRR CAP must be submitted within 30 calendar days from the date of the written CAP request

### Physicians with a Not Pass Score

A score of 79 percent or below and survey deficiencies not corrected within the established CAP timelines will not have new members assigned until all deficiencies are corrected and the CAP is closed. The CAP must be completed, submitted timely, fully accepted, and verified or a follow-up visit must be conducted for a focused review with a passing score.

PCPs who do not come into compliance with review criteria and CAP requirements may be removed from the network and have membership reassigned. If the PCP remains in the network, membership panels will be closed until the CAP is completed, all deficiencies are corrected according to the CAP timelines and the PCP will be monitored for subsequent fails.

In compliance to the Department of Health Care Services, Medi-Cal Managed Care Division All Plan Letter 22- 017, all Medi-Cal Managed Care Health Plans in the county must be notified of physicians and sites with Not Pass scores.

## CAP Extension

Within 30 calendar days from the date of the completed FSR, Providers can request a definitive, time-specific extension period to correct Critical Element deficiencies, and to be granted at the discretion of Molina, not to exceed 60 calendar days from the date of the FSR. For sites that were granted an extension for CE CAPS, Molina must verify that all CE CAPS are closed within 60 calendar days from the date of the FSR.

The Provider may request a definitive, time-specific extension period to correct non-critical CAPs that does not exceed 120 calendar days from the date of the FSR and/or MRR survey findings report and CAP notification. The request shall be submitted through a formal written explanation of the reason(s) for the extension.

Any extension beyond 120 calendar days requires an approval from the Department of Health Care Services and agreed upon by the health plan.

NOTE: AN EXTENSION PERIOD BEYOND 120 CALENDAR DAYS TO COMPLETE CORRECTIONS REQUIRES THAT THE SITE BE RESURVEYED WITH A FOCUSED FSR AND/OR MRR WITHIN 12 MONTHS OF THE ORIGINAL FSR AND/OR MRR DATE(S) PRIOR TO CLOSING THE CAP.

## CAP Completion

Physicians or their designees can complete the CAP:

- Review and correct the identified deficiencies in Column Two and Column Three of the CAP form
- Review and implement the recommended corrective actions in Column Four of the CAP form and provide appropriate attachments or documents that address the deficiencies
- Enter the date of completion or implementation of the corrective action in Column Five of the CAP form
- Document specific comments on implemented activities to address and satisfy the corrective action(s) and document a responsible designee's initials in Column Six of the CAP form
- Document the signature and the title of the physician or the designee who is responsible for completing the CAP in Column Seven of the CAP form
- Upon implementation, completion and documentation of the entire corrective action items identified on the CAP form, submit the completed CAP form

## CAP Submission

The physician, at his/her discretion, may involve any or all IPAs/Medical Groups or management companies with which the physician is contracted to assist in completion of the CAP.

The CAP must be submitted to the Site Review team at Site_Review_CAPS@MolinaHealthCare.Com

## Identification of Deficiencies Subsequent to an Initial/Periodic Site Review

Any MHC Director or Manager shall refer concerns regarding member safety and/or quality of care issues to appropriate Department(s) for necessary follow-up activities.

Member complaints related to physical office site(s) are referred to appropriate MHC Department(s) for subsequent investigation that may include performing an unannounced onsite facility review and follow-up of any identified corrective actions.

# DEPARTMENT OF HEALTH CARE SERVICES (DHCS) REVIEW OF MOLINA HEALTHCARE'S PERFORMANCE OF FACILITY SITE REVIEWS

### Review Process

An oversight audit of MHC and contracted physicians and facilities will be conducted by the DHCS.

- These visits may be conducted with or without prior notification from the DHCS

If a prior notification is given, the sites selected by the DHCS for oversight reviews will be contacted to arrange a visit schedule by either the DHCS auditor or MHC.

MHC will provide any necessary assistance required by the DHCS in conducting facility oversight evaluations.

### Requirements and Guidelines for FSR and MRR

For complete Facility Site Review and Medical Record Review Standards and Tools, please visit:
https://www.molinahealthcare.com/providers/ca/medicaid/manual/site_review.aspx

# 30. CREDENTIALING: CREDENTIALING AND RECREDENTIALING

The purpose of the Credentialing Program is to strive to assure that Molina network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Molina provider services representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer Providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA). In accordance with those standards, Molina Members will not be referred and/or assigned to you until the credentialing process has been completed and added to the Health Plan systems. The Credentialing Program is reviewed annually, revised, and updated as needed.

## Non-Discriminatory Credentialing and Recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g. Medicaid) in which the Practitioner specializes. This does not preclude Molina from including in its network Practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

## Type of Practitioners Credentialed & Recredentialed

Practitioners and groups of practitioners with whom Molina contracts must be credentialed prior to the contract being implemented.

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral healthcare practitioners who are licensed, certified or registered by the state to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's-level psychologists

- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioner

## HIV/AIDS Specialist

Molina requires Practitioners to submit a complete, signed and dated HIV/AIDS Specialist form to identify appropriately qualified specialists who meet the definition of an HIV/AIDS specialist under California Code of Regulations Section 1374.16 of the Act.

## Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the Molina network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

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

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete, and it will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

- **Application** - Practitioners must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments
- **License, Certification or Registration** - Practitioners must hold current and valid unrestricted license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine practitioners are required to be licensed in the state where they are located and the State the member is located
- **DEA or CDS Certificate** - Practitioners must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Practitioners must have a DEA or CDS in every State where the Practitioners provides care to Molina Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number.
- **Specialty** – Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Molina Members
- **Education** - Practitioners will only be credentialed in an area of practice in which they have adequate education. Provider must have graduated from an accredited school with a degree in their designated specialty
- **Residency Training** - Practitioners must have satisfactorily completed a residency program from an accredited training program in the specialties in which they are practicing. Molina only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three-year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry
- **Fellowship Training** – If the Practitioner is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in

which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing

- **Board Certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Foot and Ankle Surgery (ABFAS)
  - American Board of Podiatric Medicine (ABPM)
  - American Board of Oral and Maxillofacial Surgery
  - American Board of Addiction Medicine (ABAM)
  - College of Family Physicians of Canada (CFPC)
  - Royal College of Physicians and Surgeons of Canada (RCPSC)
  - Behavioral Analyst Certification Board (BACB)
  - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners** – Practitioners who are not board certified and have not completed a training from an accredited program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Molina will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner, if the Practitioner is applying to participate as a Primary Care Physician (PCP), or as an Urgent Care or Wound Care Practitioner. General Practitioners providing only wound care services do not require five years of work history as a PCP
- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, the Practitioner providing the supervision and/or oversight must also be contracted and credentialed with Molina
- **Work History** – Practitioner must supply most recent five years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the Practitioner must clarify the gap verbally or in writing. The organization will document a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one year, the Practitioner must clarify the gap in writing
- **Malpractice History** –Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioners must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions,

reductions, limitations, sanctions, probations and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent

- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioners must not be currently sanctioned, excluded, expelled or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner
- **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business
- **Professional Liability Insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioners activities on Molina's behalf. Practitioners maintaining coverage under Federal tort or self- insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance
- **Inability to Perform** – Practitioner must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner

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

- **Lack of Present Illegal Drug Use** – Practitioners must disclose if they are currently using any illegal drugs/substances
- **Criminal Convictions** – Practitioners must disclose if they have ever had any of the following:
    - Criminal convictions including guilty pleas or adjudicated pretrial diversions for crimes against person such as murder, rape, assault and other similar crimes.
    - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
    - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
    - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
    - Any crime related to fraud, kickbacks, healthcare fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of healthcare, patient abuse or neglect, controlled substances, or similar crimes.

  At the time of initial credentialing, Practitioners must not have any pending criminal charges in the categories listed above.
- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing
- **NPI** – Practitioners must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS)

## Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

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

Practitioners have the right to correct erroneous information in their credentials file. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

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

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

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

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

## Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

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

The only items in the file that may be copied by the Practitioner are documents, which the Practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

## Practitioner's Right to be Informed of Application Status

Practitioners have the right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner's rights are published on the Molina website and included in this Provider Manual. Molina will respond to the request within two working days. Molina will share with the Practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

## Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Molina Medical Director within two weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than 60 calendar days from the decision. Notification of recredentialing approvals are not required.

## Recredentialing

Molina recredentials every Practitioner at least every 36 months.

## Excluded Practitioner Providers

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

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

## Ongoing Monitoring of Sanctions and Exclusions

Molina monitors the following agencies for Practitioners sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Practitioners when occurrences of poor quality is identified. If a Molina Practitioners is found to be sanctioned or excluded, the Practitioner's contract will

immediately be terminated effective the same date as the sanction or exclusion was implemented.

- The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs
- State Medicaid Exclusions - Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent)
- Medicare Exclusion Database (MED) - Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- Medicare Preclusion List – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- National Practitioner Database - Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- System for Award Management (SAM) – Monitor for Practitioners sanctioned by SAM

Molina also monitors the following for all Practitioner types between the recredentialing cycles:

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

## Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to Laws or regulations.

# 31. DELEGATION

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

1. Utilization Management
2. Credentialing, Recredentialing and Provider Medi-Cal Screening and Enrollment
3. Sanction Monitoring for employees and contracted staff at all levels
4. Claims

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 compliant 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, quarterly reports and adhoc reports in a format determined by Molina. Such reports will be determined by the function(s) delegated and will be reviewed by Molina Delegation Oversight staff for compliance with performance expectations within the timeline and format 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 impose administrative and/or financial sanctions or revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

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

## Delegation Criteria

An entity may request Credentialing, Utilization Management or Claims delegation from Molina through Molina's Delegation Oversight Director/Manager or through their Contract Manager. Molina will request a potential delegate to submit policies and procedures for review and will schedule a time for an onsite pre- assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee

(DOC) for review and approval. Final decision to delegate is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation of the function.

## Sanction Monitoring

All Delegates are required to have processes to screen staff and employees at all levels against Federal and State exclusion lists. Screening must be done prior to the employee/staff's hire date and occur monthly thereafter.

Molina will include a Sanction Monitoring pre-assessment audit with all other pre-assessment audits, any time a function(s) is/are being considered for delegation.

Sanction Monitoring functions may be delegated to entities that meet Molina criteria. To be delegated for sanction monitoring functions, potential delegates must at minimum:

- Pass Molina's sanction monitoring pre-assessment and annual audits, which are based on OIG standards
- Demonstrate that employees and staff are screened against Office of Inspector General (OIG) and System for Award Management (SAM) sanction lists prior to hire dates, and monthly thereafter
- Correct deficiencies within Molina approved timeframes when issues of non-compliance are self-reported by a delegated entity or identified by Molina
- Agree to Molina's contract terms and conditions for sanction monitoring delegates
- Submit timely and complete Sanction Monitoring delegation reports as detailed in the Delegated Services Addendum or as communicated by Molina to the applicable Molina contact
- Comply with all applicable accreditation and regulatory standards and applicable Federal and State Laws
- When staff or employees are identified as having a positive sanction, provide Molina with notification according to Contractual Agreements of the findings and action(s) being taken to ensure sanctioned staff is not providing services to Molina Members
- Provide a 90-day advance notification to Molina of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate and participate when applicable, in Health Plan, legal and regulatory inquiries and audits

## Credentialing

Credentialing functions may be delegated to entities that meet National Committee for Quality Assurance© (NCQA) criteria for credentialing functions.

To be delegated for credentialing functions, potential delegates must at minimum:

- Pass Molina's credentialing pre-assessment and annual audits, which are based on NCQA credentialing standards, contract requirements and state and federal regulatory requirements

- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval, or denial/termination of practitioners included in delegation
- Have an ongoing monitoring process in place that screens all practitioners included in delegation against OIG and SAM, and exclusion lists a minimum of every 30 days
- Have a process to screen, and revalidate monthly or periodically, all network providers for Medi-Cal enrollment in compliance with regulatory requirements. Delegates must terminate their contract with a provider no later than 15 calendar days of the provider receiving notification from DHCS that the provider has been denied enrollment in the Medi-Cal program, or upon expiration of the 120-day period in which the provider was unsuccessful in enrolling. Have internal controls and quality monitoring of work performed by Credentialing staff
- Correct deficiencies within Molina established timeframes when issues of non-compliance are identified by Molina or a state or federal regulatory agency
- Agree to Molina's contract terms and conditions for credentialing delegates
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum or as communicated by Molina to the applicable Molina contact
- Comply with all applicable accreditation and regulatory standards and applicable Federal and State Laws
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members
- Provide a 90-day advance notification to MHC of its intent to sub-delegate and include pre- delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate and participate when applicable, in Health Plan, legal and regulatory inquiries and audits

**Note:** If the Provider is an NCQA certified or accredited organization, a modified pre-assessment audit may be conducted. Modification to the audit depends on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions, or demonstrate an ability to meet all Health Plan, NCQA, and State and Federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and recredentialing files, and a process to implement corrective action if issues of non-compliance are identified.

## Utilization Management

Utilization Management (UM) functions may be delegated to entities that meet National Committee for Quality Assurance© (NCQA) criteria, regulatory and Molina established standards for utilization management functions and processes.

To be delegated for utilization management functions, potential delegates must at minimum:

- Pass Molina's Utilization Management pre-assessment and annual audits, which are based on regulatory, NCQA UM and Molina established standards and state and federal regulatory requirements
- Have a multi-disciplinary Utilization Management Committee who is responsible for oversight of the UM program, review and approval of UM policies and procedures and ensuring compliance of the UM processes and decisions
- Have a full time Medical Director responsible for the UM program and holds an unrestricted license to practice medicine in California
- Have internal controls and quality monitoring of work performed by the UM staff
- Correct deficiencies within Molina established timeframes when issues of non-compliance are self-identified, identified by Molina or a state or federal regulatory agency
- Agree to and cooperate with Molina's contract terms and conditions for utilization management delegates.
- Submit timely and complete Utilization Management delegation reports in a format and frequency determined by Molina
- Comply with all applicable accreditation and regulatory standards and applicable Federal and State Laws.
- Provide a 90-day advance notification to Molina of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate and participate when applicable, in Health Plan, legal and regulatory inquiries and audits.
- Comply with contractual, regulatory and legal requirements for member and provider notification of utilization management decisions
- Prohibit the use of verbal denials and other intangible methods of documenting physician review unless otherwise allowed by regulation or law

## Claims

Claims functions may be delegated to entities that demonstrate the ability to meet regulatory and Health Plan requirements for Claims functions. To be delegated for Claims functions, potential delegates must at minimum:

- Pass Molina's Claims pre-assessment and annual audits, which are based on state and federal laws and regulatory and Molina established standards
- Have internal controls and quality monitoring of work performed by Claims staff
- Correct deficiencies within Molina established timeframes when issues of non-compliance are identified by Molina or a state or federal regulatory agency

- Agree to Molina's contract terms and conditions for Claims delegates
- Submit timely and complete Claims delegation reports as detailed in the Delegated Services Addendum or as communicated by Molina to the applicable Molina contact
- Comply with all regulatory standards and applicable Federal and State Laws
- Have systems enabled to accurately and timely adjudicate professional and facility claims, including but not limited to the appropriate application of interest penalties, edits, audit trail, fee schedule, provider contracting status, denial codes, payment codes, pend codes and accumulators
- Provide a 90-day advance notification to Molina of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process
- In a timely and appropriate manner, respond, cooperate and participate when applicable, in Health Plan, legal and regulatory inquiries and audits

## Oversight Monitoring of Delegated Functions

Prior to approval of delegation, and at least annually thereafter, Molina conducts an onsite review of IPAs/Medical Groups requesting delegation. Molina uses delegation standards and practices in compliance with NCQA, State and Federal Requirements. A member or designee of the Delegation Oversight team assigned to evaluate and oversee the IPAs/Medical Groups activities conducts the audit. Based on the audit scores and findings, if required thresholds and criteria are met, the appropriate Committee may approve specific delegation of functions to the IPA/Medical Group to perform. Once approved for delegation, an "Acknowledgement Acceptance of Delegation" must be signed between Molina and the IPA/Medical Group. For delegation of utilization management, a "Delineation of Utilization Management Responsibilities" grid is included with the Acknowledgement and Acceptance of Delegation", outlining the delegated activities; Molina's Responsibilities; the Delegated IPA/Medical Group Responsibilities; the Frequency of Reporting; Molina's Process for Evaluating Performance; and Corrective Actions if the IPA/Medical Group fails to meet its responsibilities. Adhoc audits may be conducted at the discretion of the Health Plan.

Molina reserves the right to request corrective action plans, sanction or revoke the delegation of these responsibilities when the Delegated group demonstrates noncompliance to NCQA, contractual, State and Federal Requirements.

Delegates must comply with all applicable State and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters (APLs) and Policy Letters.

Complex Case Management services are not delegated to IPAs/Medical Groups. IPAs/Medical Groups are required to refer known or potential cases to MHC Case Management. The referral may be made by a telephone or facsimile. This information can also be found in the Medical Management Section and in the Public Health Coordination and Case Management.

## Member Confidential Communication

To the extent applicable to the function delegated, the Delegated Entity shall comply with the requirements of California Civil Code Section 56.107, and any other similar laws, which provide Members with the right to confidential communications, including confidential communications with respect to certain sensitive services ("Confidential Communications"). The Delegated Entity shall comply with any direction by Molina with respect to Confidential Communications with a designated Member. If the Delegated Entity handles delivery or transmission of Confidential Communications, responding to a Member's request for Confidential Communications, or other services involving Confidential Communications, the Delegated Entity shall comply with Molina's policies, procedures, manuals and instructions regarding Confidential Communications including, but not limited to the following requirements:

Delegated Entity shall not require a protected individual to obtain the Subscriber's, or other Member's authorization to receive sensitive services or to submit a claim for sensitive services if the protected individual has the right to consent to care.

Delegated Entity shall recognize the right of a protected individual to exclusively exercise rights granted under the California Confidentiality of Medical Information Act regarding medical information related to sensitive services that the protected individual has received.

Delegated Entity shall direct all communications regarding a protected individual's receipt of sensitive services directly to the protected individual receiving care as follows:

- If the protected individual has designated an alternative mailing address, email address, or telephone number pursuant to a Confidential Communications request, Delegated Entity shall send or make all communications related to the protected individual's receipt of sensitive services to the alternative mailing address, email address, or telephone number designated.
- If the protected individual has not designated an alternative mailing address, email address, or telephone number pursuant to a Confidential

Communications request, the Delegated Entity shall send or make all communications related to the protected individual's receipt of sensitive services in the name of the protected individual at the address or telephone number on file.

Communications subject to confidential communication requirements include the following written, verbal, or electronic communications related to the receipt of sensitive services:

(i) Bills and attempts to collect payment.

(ii) A notice of adverse benefits determinations.

(iii) An explanation of benefits notice.

(iv) A Delegated Entity's request for additional information regarding a claim.

(v) A notice of a contested claim.

(vi) The name and address of a provider, description of services provided, and other information related to a visit.

(vii) Any written, oral, or electronic communication from a Delegated Entity that contains protected health information.

Delegated Entity shall not disclose medical information related to sensitive health care services provided to a protected individual to the Subscriber or any Molina Members other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

Molina reserves the right to audit the delegated entity's operations to confirm compliance with the requirements contained herein.

## PCP Termination and Member Reassignment Policy

The guidelines outlined in this policy are intended to retain the accuracy of our network while keeping the Members care as a priority. Scenarios outside of this policy will be researched and decisions will be made in the best interest of the member.

**Directly Contracted PCPs**

| Scenario | Action |
|---|---|
| Terming PCP practices under a group contract | Members will remain with the Group |
| Terming PCP practices under a solo contract | Member will be assigned within the Network |

**IPA's/ Medical Groups**

| Scenario | Action |
|---|---|
| Terming PCP practices in a Federally Qualified Health Center (FQHC) | Member will remain with the FQHC |
| Federally Qualified Health Center (FQHC) is moving from one IPA to another | Member will remain with the FQHC |
| Terming PCP is a solo practitioner and is affiliated with multiple IPA | Member will remain with the PCP and be transitioned to the still contracting IPA to ensure members continuity of care. |
| If PCP is being admiratively terminated by Molina or the IPA for such reasons as malpractice insurance, suspension of license, or failure to pass Facility Site Review | Member will remain with the IPA |
| If an IPA wishes to have members reassigned to PCPs within the IPA at time of provider termination, The IPA must make those assignments know at the time of notice. | Molina will make every effort to accommodate the request subject the Members right to choose their PCP. |

# 32. RISK ADJUSTMENT MANAGEMENT PROGRAM

## What is Risk Adjustment?

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 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 identifies 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 utilize the annual visit (for all new and existing patients) to perform a comprehensive assessment of their chronic conditions and current health status. Document and code all diagnoses to the highest specificity as this will ensure Molina receives adequate resources to provide quality programs to you and our Members.

For 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 Provider visit with a Member. The visit may be face-to-face, or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.

## Interoperability

Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by Provider's Electronic Medical Records (EMR), including, but not limited to, Direct protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource). CCDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) CCDA standard.

Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If Provider does not have Direct Address, Provider, will work with its EMR vendor to set up a Direct Account, which also supports the Centers for Medicare & Medicare Services (CMS) requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).
- If Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.

## 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 your Molina Provider Services representative.

# 33. PROPOSITION 56: DIRECT & DELEGATED ENTITIES OR SUBCONTRACTORS

## Proposition 56

**APL 19-013 – Proposition 56 Hyde Reimbursement Requirements for Specific Services:**

MHC will pay the providers that are qualified to provide and bill for medical pregnancy termination services with dates of services on or after July 1, 2017, using Proposition 56 appropriated funds. Consistent with the enacted budgets. MHC will also pay at least the rate for Current Procedural Terminology – 4th Edition (CPT-4) code 59840 in the amount of $400 and CPT-4 code 59741 in the amount of $700. This payment obligation applies to contracted and non-contracted providers. This required reimbursement level will be accounted for MHC's capitation rate.

**APL 22-019 – Proposition 56 Value-Based Payment Program Directed Payments (Supersedes APL 20-014):** Subject to obtaining the necessary federal approvals and consistent, MHC will make directed payments for qualifying VBP program services for dates of service from **July 1, 2019, through June 30, 2022,** in the specified amounts for the appropriate procedure codes, in accordance with the CMS-approved preprint. The directed payments must be in addition to whatever other payments eligible Network Providers. Services performed after June 30, 2022, are not eligible to receive VBP enhanced payments. **APL 19-015 – Proposition 56 Directed Payments for Physician Services:**

Proposition 56 appropriated funds will result in directed payments by MHC's delegated entities and subcontractors (as applicable) to individual providers rending specified services with the dates of service. DHCS is requiring MHC's delegated entities and subcontracts, to make directed payments for qualifying services in the amounts and for the CPT codes. MHC is responsible for ensuring these directed payments are received by the individual rendering providers who are eligible providers. The directed payments shall be in addition to whatever other payments eligible providers would normally receive from MHC, or MHC's delegated entities and subcontractors.

Eligible providers who are the individual rendering providers qualified to provide and bill for the CPT codes. Federally Qualified Health Centers, Rural Health Clinics, and American Indian Health Programs, as well as Cost-Based Reimbursement Clinics are not eligible Providers. A qualifying service is one provided by an eligible Providers where a specified service is provided to a member enrolled in MHC, who is not dually eligible for Medi-Cal and Medicare Part B.

**APL 19-016 – Proposition 56 Developmental Screening:**

MHC will make directed payments to eligible Network Providers of $59.90 for each qualifying developmental screening service with dates of service on or after January 1, 2020, in accordance with the CMS-approved preprint, which will be made available on

the DHCS' Directed Payments Program website upon CMS approval. These directed payments must be in addition to whatever other payments the Network Providers would normally receive from MHC, or MHC's delegated entities and Subcontractors, as Network Providers.

A qualifying developmental screening service is one provided by a Network Provider, in accordance with the AAP/Bright Futures periodicity schedule and through use of a standardized tool that meets the criteria specified below, to a Member enrolled with MHC who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). MHC is responsible for ensuring that qualifying developmental screening services are reported to DHCS in encounter data in accordance with APL 14-019, "Encounter Data Submission Requirements," using Current Procedural Terminology (CPT) code 96110 without the modifier KX. The KX modifier is used to document screening for Autism Spectrum Disorder (ASD). ASD screening is different from general developmental screening, and while both types of screening are AAP/Bright Futures recommendations, only general developmental screenings are eligible for a directed payment. MHC is responsible for ensuring that the encounter data reported to DHCS is appropriate for the services being provided, and that CPT code 96110 without the modifier KX is not reported for non-qualifying developmental screening services or for any other services.

A qualifying developmental screening service must be performed using a standardized tool that meets each of the following CMS criteria:

1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
2. Established Reliability: Reliability scores of approximately 0.70 or above.
3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Providers must document each of the following: the tool that was used; that the completed screen was reviewed; the results of the screen; the interpretation of results; discussion with the Member and/or family; and any appropriate actions taken. This documentation must remain in the Member's medical record and be available upon request. The provider must document completion of the developmental screening with CPT code 96110 without the modifier KX. Additional developmental screenings done when medically necessary due to risk identified on developmental surveillance are also eligible for directed payment if completed with standardized developmental screening tools and documented with CPT code 96110 without the modifier KX.

**APL 19-018 – Proposition 56 Directed Payments for Adverse Childhood Experience Screening:**

A qualifying ACEs screening service is one provided by a Network Provider through the use of either the PEARLS tool or a qualifying ACEs questionnaire to a Member enrolled to MHC who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). To qualify, the ACEs questionnaire must include questions on the 10 original categories of Aces. Providers may utilize either an ACEs questionnaire or the PEARLS tool for Members 18 or 19 years of age; the ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adults ages 20 years and older. Providers must calculate the score for the billing codes using the questions on the 10 original categories of ACEs.

Providers may screen Members utilizing a qualifying ACEs questionnaire or PEARLS tool as often as deemed appropriate and medically necessary. However, MHC is only required to make the $14.50 required minimum payment to a particular Network Provider once per year per Member screened by that Provider, for a child Member assessed using the PEARLS tool, and once per lifetime per Member screened by that Provider, for an adult Member (through age 64) assessed using a qualifying ACEs questionnaire.

To be eligible for the directed payment, the Network Provider must meet the following criteria:

1. Provider must utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;
2. Provider must bill using one of the HCPCS codes in the table above based on the screening score from the PEARLS tool or ACEs questionnaire used; and
3. Provider must render the screening on the DHCS' list of Providers that have completed the state-sponsored trauma-informed care training. The training requirement will be waived for dates of service prior to July 1, 2020. However, commencing July 1, 2020, Network Providers must have taken a certified training and self- attested to completing the training to receive the directed payment for ACEs screenings.

Providers must document each of the following: the tool that was used; that the completed screen was reviewed; the results of the screen; the interpretation of results; what was discussed with the Member and/or family; and any appropriate actions taken. This documentation must remain in the Member's medical record and be available upon request.

**ACEs Trainings:**

ACEs Aware is hosting a series of activities to promote shared learning and quality improvement among Medi- Cal providers in adopting ACE Screenings and providing trauma-informed care. These webinars will provide an overview of the ACEs Aware initiative; why providers should screen for ACEs; the Medi-Cal certification and payment process; and screening tools, clinical protocols, and resources for providers. This series

of webinars will offer practical information to help providers integrate ACEs screening and response into their clinic and workflows. The training will include general training about trauma-informed care, as well as specific training on use of the ACEs questionnaire and PEARLS tool. It will also include training on ACEs Screening Clinical Algorithms to help Providers assess patient risk of toxic stress physiology and how to incorporate ACEs screening results into clinical care and follow-up plans. For more information regarding training, please visit: https://www.acesaware.org/heal/educational-events/

**APL 20-013- Proposition 56 Directed Payments Family Planning Services:**

Subject to obtaining the necessary federal approvals and budgetary authorization and appropriation by the California Legislature, DHCS is requiring MHC to pay qualified contracted and non-contracted Providers a uniform and fixed dollar add-on amount for the specified family planning services (listed below) provided to a Medi-Cal managed care member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D), with dates of service on or after July 1, 2019, in accordance with the CMS-approved preprint for this program, which will be made available on DHCS' Directed Payments Program upon CMS approval: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

Please refer to cover letter for payment information.

## How to File a Provider Grievance

Providers may initiate a grievance related to directed, supplemental and/or incentive-based payments by contacting the Provider Services Team and/or submitting by fax or mail. The following documentation is required to review and process a Provider grievance:

- Payment Cover Letter, Invoice Summary or a Letter of Explanation
  - If providing the letter of explanation, please be sure to include the provider tax identification number (TIN) or the national provider identifier (NPI)
- Documented reason for provider grievance related to payment discrepancy

**Fax: (562) 499-0633**

- Must include provider's fax number to receive the resolution of the dispute via fax
- Must include applicable supporting documents to justify grievance, if applicable

**Provider Grievances and supporting documentation (via paper) should be submitted to:**

Molina Healthcare of California
P.O. Box 22722
Long Beach, CA 90801
Attn: Provider Grievance and Appeals Unit

Please email: mhcprovideredcomm@MolinaHealthcare.com to receive corresponding claim details electronically.

## IPA Reporting Requirements to MHC

MHC is required to ensure that delegated entities distribute Prop 56 payments to providers in an accurate and timely manner.

Instructions: If you receive a Prop 56 Distribution Summary form with the requested information, complete and return the Prop 56 Payment Distribution Summary form to Prop56_Payment_Depo@MolinaHealthcare.com with the following columns completed for each provider paid, no later than 30 calendar days from the date of receipt.

Evidence of Payment:

- Check Date
- Paid Amount
- Check No.

| Evidence of Payment | | |
|---|---|---|
| Check Date | Paid Amount | Check No. |
| | | |

Please maintain all records of provider payment consistent with regulatory record retention standards (CMS Final Rule, Title 42 Section 422.504). MHC may request payment evidence as part of the monitoring and audit activities.

# 34. ENHANCED CARE MANAGEMENT

Enhanced Care Management (ECM) is a Medi-Cal benefit available to qualifying members as part of the DHCS CalAIM initiative. Starting January 1, 2022, Medi-Cal plans offered Enhanced Care Management (ECM). ECM is defined as comprehensive, whole-person care management that will be available to high-need, high-cost Medi-Cal Managed Care enrollees with the goals of better coordinating care, addressing social determinants of health, and improving health outcomes.

The goal of ECM is to address the clinical and non-clinical needs of members with the most complex medical and social needs through systematic coordination of services and comprehensive care management. The benefit is community based, interdisciplinary, high touch and person centered.

The ECM benefit builds on the previous Health Homes (HH) Program and Whole Person Care (WPC) Pilots and replaced both initiatives, effective 1/1/2022.

Qualifying members remain enrolled in their managed care plan and continue to see the same doctors but have an extra layer of support through ECM. This is a voluntary benefit and is free as part of members' Medi-Cal benefits. Program objectives include:

- Reduce hospital admission, ED visits and SNF admissions
- Leverage existing community care management infrastructure
- Address social determinants of health (SDOH)

To be eligible for ECM, Members must be enrolled in Medi-Cal Managed Care and meet the criteria established by DHCS for each of the ECM Populations of Focus (PoF). The PoFs are as follows:

- Individuals experiencing homelessness (all Molina Medi-Cal counties)
- Adult High Utilizers (all Molina Medi-Cal counties)
- Adults with Serious Mental Illness (SMI) or Substance Use Disorder (SUD) (all Molina Medi-Cal counties)
- Individuals Transitioning from Incarceration (Riverside and Los Angeles counties only)
- Adults living in the community who are at risk for LTC (Long Term Care) institutionalism
- Nursing facility residents transitioning to the community
- The Children and Youth PoF will be eligible to receive ECM services starting in July of 2023.

## Timeline

ECM has been phased in by population of focus and county beginning January 1, 2022, starting with counties that implemented Whole Person Care Pilots and Health Homes Programs. Members enrolled in HHP/WPC as of 12/31/21 were automatically enrolled in ECM effective 1/1/2022. These members were re-assessed in six months for ECM

eligibility and continuation of services. Some of these members also receive Community Supports if they were receiving these services through HHP or WPC.

## ECM Eligibility and Exclusions

Members cannot participate in ECM if they:

- Receive Hospice Services
- Are a Cal MediConnect (MMP/Duals) member
- Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
- Program for All-Inclusive Care for the Elderly (PACE)
- Mosaic Family Services

Duplicative programs – Members must choose either ECM or one of the following Medi-Cal funded programs:

- 1915(c) Waiver Programs: Home and Community Based (HCBS), HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), Multipurpose Senior Services Program (MSSP)
- Complex Case Management (through Molina CM)
- Basic Care Management (through their PCP)
- California Community Transitions (CCT) Money Follows the Person (MFTP)

Members can receive services through both ECM and other programs:

- California Children's Services (CCS)
- Genetically Handicapped Person's Program (GHPP)
- County-based Targeted Case Management (TCM), including Specialty Mental Health (SMHS) TCM
- SMHS Intensive Care Coordination for Children (ICC)
- Specialty Mental Health and Drug Medi-Cal Organized Delivery Systems (DMC-ODS)
- Community Based Adult Services (CBAS)

## The ECM Provider

Each member is assigned to a provider or agency who is responsible for the provision of the ECM benefit. ECM services consist of providing intensive, in-person care management and care coordination. Molina contracts with variety of providers, including but not limited to, IPAs, FQHC's, community-based organizations and housing services agencies to act as ECM Providers. Molina assigns members to the ECM provider who will best suit their identified needs, in alignment with their population of focus, provider experience and expertise, and member preferences. When possible and appropriate, the assigned ECM provider may also serve as the member's assigned primary care provider (PCP). Members have the option to change their ECM provider if they choose by contacting Molina's Member Services department. The member will have access to the ECM care team, which includes a lead case manager who is assigned to manage the member's case and coordinate care. If the ECM provider is not the member's

assigned primary care provider, the ECM provider must maintain a strong connection to the PCP and other members of the care team to ensure their participation in the development and implementation of the individualized care plan. The member's ECM lead case manager will encourage them to visit their doctor and may arrange transportation or accompany members to the doctors at the member's request. The ECM provider may contact the PCP and other specialists or providers to request medical information, for example blood pressure or medication information, which are part of the program reporting and operational requirements.

## ECM Benefits and Services

ECM Core Services are centered around a whole-person approach with a focus on in-person services as follows:

1. Outreach and Engagement
2. Comprehensive Assessment and Care Plan
3. Enhanced Care Coordination
4. Health Promotion
5. Comprehensive Transitional Care
6. Individual and Family/Social Support Services
7. Coordination of and Referral to Community and Social Support Services

**Outreach and Engagement:** In person, culturally and linguistically appropriate

**Comprehensive Assessment and Care Management:** Assess member strengths, risks, needs, goals, gaps in care and their preferences.

- The ECM provider will conduct an assessment and will create the ICP within 90 days of the member opting into ECM. Members are reassessed and the ICP is modified at a minimum of every six months or more frequently when the member's condition changes.
- The Individualized Care Plan: Once enrolled in ECM, their ECM provider will assess the member's health needs, goals, and current providers. The member will be assigned a lead case manager who will work with them to make a plan for getting the health care and community services they need. The individualized care plan (ICP) guides the member's services and care, and is based on the member's health status, needs, preferences, and goals regarding: physical and mental health, substance use disorders, community-based long-term services and supports, including housing, palliative care, and trauma-informed care needs.

**Enhanced Coordination of Care:** Ensure care is continuous and integrated among all service providers

**Health Promotion:** Promote self-management, collaborate to identify and build on successes and resiliencies.

**Comprehensive Transitional Care:** Develop strategies to reduce avoidable member admissions and readmission.

**Individual and Family Supports:** Identify supports needed to manage the member's condition and assist them in accessing needed support services.

**Coordination of and Referral to Community and Social Supports:** Coordinate and refer to available community resources and follow up to ensure services were rendered – "closed loop referrals.

Members who are in the qualifying ECM PoFs may be referred to Molina for review through the Member Services department or through the ECM Referral Form located on https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ca/Medicaid/forms/Enhanced-Care-Management-Member-Referral-Form.pdf.

For more information on ECM and the DHCS CalAIM initiative, please visit the DHCS CalAIM website.

# 35. COMMUNITY SUPPORTS

Starting January 1, 2022, Medi-Cal plans will offer Community Supports (CS). CS are services or settings that may be offered in place of services or settings covered under the California Medicaid State Plan and that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. CS are optional to offer and for Members to utilize. Members are not required to use a CS instead of a service or setting listed in the Medicaid State Plan.

Medi-Cal managed care plans will have the option to integrate CS into their population health management plans – often in combination with the new enhanced care management benefit.

CS must be cost effective and may not be duplicative from other State, local tax, or federally funded programs, which should always be considered first, before using Medi-Cal funding. For example, CS might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays and emergency department use.

Molina will be offering the following CS:

| Community Support Services | Counties | | | | | |
|---|---|---|---|---|---|---|
| | Riverside | San Bernardino | Sacramento | San Diego | Imperial | Los Angeles |
| Housing Transition Navigation Services | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Housing Deposits | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Housing Tenancy and Sustaining Services | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Short-Term Post Hospitalization | ✓ | ✓ | ✓ | ✓ | | ✓ |
| Recuperative Care (Medical Respite) | ✓ | ✓ | ✓ | ✓ | | ✓ |
| Community Transition Services / Nursing Facility Transition to a Home | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities | ✓ | ✓ | | | | |
| Respite Services (Home) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Personal Care and Homemaker | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Day Habilitation Programs | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Medically Tailored Meals** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Sobering Centers** | ✓ | | ✓ | ✓ | | ✓ |
| **Asthma Remediation** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

## CS Descriptions and Eligibility Criteria:

**Housing Transition Navigation Services:** Assists members experiencing homelessness with obtaining housing by providing support with items such as housing applications, benefits advocacy, securing available resources, and providing help with landlords upon move-in.

- Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or
- Members who meet the Housing and Urban Development (HUD) definition of homeless; or
- Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; or
- Members at risk of experiencing homelessness and have one or more serious chronic conditions; have a serious mental illness; are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); are receiving Enhanced Care Management (ECM); or are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

**Housing Deposits:** Assists members experiencing homelessness with identifying, coordinating, securing or funding one-time services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as providing security deposits. These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the member is unable to meet such expense.

- Members who received Housing Transition/Navigation Services Community Supports; or
- Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or
- Members who meet the Housing and Urban Development (HUD) definition of homeless and who are receiving Enhanced Care Management (ECM), or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder.

**Restriction/Limitation:**

- Housing Deposits are available once in an individual's lifetime with a lifetime maximum of $5,000. Housing Deposits can only be approved one additional time. Referrer must provide documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt.

**Housing Tenancy and Sustaining Services:** Provides tenancy and sustaining services to maintain safe and stable residency once housing is secured for members who had been experiencing homelessness and are now newly housed.

- Members who received Housing Transition/Navigation Services Community Supports; or
- Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or
- Members who meet the Housing and Urban Development (HUD) definition of homeless; or
- Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; or
- Members at risk of experiencing homelessness and have one or more serious chronic conditions; have a serious mental illness; are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); are receiving Enhanced Care Management (ECM); or are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

**Restriction/Limitation:**

- Housing Tenancy and Sustaining Services are only available for a single duration in the individual's lifetime and can be approved one additional time. Referrer must provide documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt.

**Short-Term Post Hospitalization:** Provides members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recover immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of State plan services.

**Restriction/Limitation:**

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are not to exceed a duration of six (6) months (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

**Recuperative Care (Medical Respite):** Provides members experiencing homelessness and needing short-term residential care and no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.

**Restriction/Limitation:**

- Recuperative Care is not more than 90 days in continuous duration.

**Community Transition Services/Nursing Facility Transition to a Home:** Assists members who have been living in a skilled nursing facility to live in the community and avoid further institutionalization by supporting members with becoming newly housed and covering nonrecurring setup expenses.

- Members currently receiving medically necessary nursing facility level of care (LOC) services and in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and
- Has lived 60+ days in a nursing home and/or Medical Respite setting; and
- Is interested in moving back to the community; and
- Is able to reside safely in the community with appropriate and cost-effective supports and services.

**Restriction/Limitation:**

- Community Transition Services/Nursing Facility Transition to a Home are available once in an individual's lifetime with a lifetime maximum of $7,500. Community Transition Services/Nursing Facility Transition to a Home can only be approved one additional time. Referrer must provide documentation that the member was compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond their control.

**Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities:** Services to assist individuals to live in the community and/or avoid institutionalization when possible. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

- Nursing Facility Transition:
  - Has Resided 60+ days in a nursing facility;
  - Willing to live in an assisted living setting as an alternative to a Nursing Facility;
  - Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

- Nursing Facility Diversion
  - Interested in remining in the community;
  - Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services;
  - Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC at an Assisted Living Facility.

**Restriction/Limitation:**

- Individuals are directly responsible for paying their own living expenses.

**Day Habilitation Programs:** Programs that are designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment.

- Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

**Respite Services (Home):** Respite services are provided to caregivers of members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

- Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.
- Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, members enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and members with Complex Care Needs.

**Restriction/Limitation:**

In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care. Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

**Personal Care and Homemaker Services:** Provides care for members who need assistance with Activities of Daily Living (ADLs)and Instrumental Activities of Daily Living (IADLs).

- Members at risk for hospitalization or institutionalization in a nursing facility or with functional deficits and no other adequate support system with:
  - Needs above and beyond any approved county In-Home Supportive Services hours when additional hours are required (pending reassessment); or
  - During any In-Home Supportive Services waiting period (Member must be already referred to In-Home Supportive Services); or
  - Members not eligible to receive In-Home Supportive Services and need help to avoid a short-term stay in a skilled nursing facility which cannot exceed 60 days.

**Medically Supportive Food/Meals/Medically Tailored Meals:** Provides meals for members recently discharged from a hospital or skilled nursing facility. Meals are delivered weekly by UPS or FedEx and are tailored to the member's dietary needs.

- Members discharged from the hospital or a skilled nursing facility who are referred and meet criteria will receive up to two meals per day, and/or medically supportive food for up to four weeks per hospitalization at a maximum of 12 weeks in a calendar year.
- Los Angeles County: Members must have a chronic condition and discharged from the hospital or skilled nursing facility; or at high risk of hospitalization or nursing facility placement; or have extensive care coordination needs.

**Sobering Centers:** Provides alternative destinations for members who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail.

- Members aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.
- The service covered is for a duration of less than 24 hours.
- Los Angeles County: Health Net will be providing authorization.

**Asthma Remediation:** Assists members by identifying, coordinating, securing, or funding services and modifications necessary to a home environment to ensure the health, welfare, and safety of the individual or to enable the individual to function in the home without acute asthma episodes, which could result in the need for emergency services and hospitalization. The referral must be signed by a licensed health care professional.

- Members with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two Primary Care Physician (PCP) or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the services will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

**Restriction/Limitation:**

- Asthma Remediation are available once in an individual's lifetime with a lifetime maximum of $7,500. Asthma Remediation can only be approved one additional time. Referrer must provide documentation describing the significant changes to condition that additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.

**Referral:**

Community Supports have referral forms to complete and submit for review as all referred members must meet the Community Supports eligibility criteria. All Community Supports require a prior authorization with the exception of Sobering Centers. Members must consent to the submitted referral and acknowledge the lifetime maximum for Housing Deposits, Housing Tenancy and Sustaining Services, Community Transition Services/Nursing Facility Transition to a Home, Short-Term Post Hospitalization, and Asthma Remediation.

Submission of the referral is an attestation that Community Supports are not duplicative from other State, local tax, or federally funded programs, which should always be considered first, before using Medi-Cal funding. Once reviewed and approved for eligibility criteria, an authorization will be provided to the accepting Community Supports provider. Upon receiving authorization, Community Supports Providers would provide services and are then eligible for reimbursement through claims submission.

Referral forms are available in the Availity Essential Portal
provider.MolinaHealthcare.com

**Claims:** Reference contract for each CS claims submissions.