



PROVIDER MANUAL

Molina Healthcare of Texas
(Molina Healthcare or Molina)

Medicaid, CHIP,
Molina Dual Options STAR+PLUS MMP

2022

STAR | Dallas, El Paso, Harris, Hidalgo, Jefferson
STAR+PLUS | Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson,
Tarrant, MRSA Northeast
CHIP/CHIP Perinate | Dallas, Harris, Hidalgo, Jefferson, Rural
Service Area
MMP | Bexar, Dallas, El Paso, Harris, Hidalgo

Provider Services | (855) 322-4080 | MolinaHealthcare.com



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

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Molina Healthcare of Texas Medicaid, CHIP, MMP Provider Manual
Any reference to Molina Healthcare Members means Molina Healthcare Medicaid, CHIP or MMP Members.
MHTPROVMN0422

**Addendum to: Provider Roles and Responsibilities
Applicable to Medicare-Medicaid Plan (MMP) Providers**

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

- (a) Definition. As used in this clause “*United States or its outlying areas*” means: (1) The fifty States; (2) The District of Columbia; (3) The commonwealths of Puerto Rico and the Northern Mariana Islands; (4) The territories of American Samoa, Guam, and the United States Virgin Islands; and (5) The minor outlying islands of Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Islands, Navassa Island, Palmyra Atoll, and Wake Atoll.
- (b) Authority. This clause implements Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985).
- (c) Compliance. The Provider, a subcontractor, shall comply with all guidance, including guidance conveyed through Frequently Asked Questions, as amended during the performance of this Agreement, for contractor or subcontractor workplace locations published by the Safer Federal Workforce Task Force (Task Force Guidance) at <https://www.saferfederalworkforce.gov/contractors/>.
- (d) Subcontracts. The Provider shall include the substance of this clause, including this paragraph (d), in subcontracts at any tier that exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award, and are for services, including construction, performed in whole or in part within the United States or its outlying areas.”

Molina Healthcare Provider Manual and Orientation Acknowledgement

Please sign and return to Molina Healthcare Provider Services acknowledging receipt of the Molina Healthcare Edition of the Provider Manual and Orientation

- _____ Molina Healthcare History and Overview
- _____ Molina Product Lines
- _____ Molina Healthcare Service Delivery Areas
- _____ Molina Benefits by Product Line
- _____ Eligibility, Claims, Appeals & Reimbursement
- _____ Children of Migrant Farm Workers (FREW)
- _____ THSteps
- _____ Medical Management (Quality Improvement, Disease Management, Case Management & Utilization Management)
- _____ Long Term Support Services (if applicable)
- _____ Prior Authorization
- _____ Out-of-Network Referrals
- _____ Provider Complaint Process
- _____ E-Portal
- _____ Behavioral Health (if applicable)

Group Practice Name: _____

Provider Name: _____

Address: _____

City/ZIP: _____

County: _____

Phone: _____

Date: _____

Name (If not Provider): _____

Signature: _____

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Quick Reference Guide

<p>Provider Services/Relations (Medicaid, CHIP & MMP) Claims Status, Complaint & Appeals Status Member Eligibility, Benefit Verification Utilization Management, Quality Improvement Prior Authorization, Referrals</p>	<p style="text-align: center;">(855) 322-4080</p> <p style="text-align: center;">MTHXProviderServices@MolinaHealthcare.com</p>
<p>Provider Online Portal Relations (Medicaid, CHIP & MMP) Member Eligibility, Claims Submission and Status, Authorization Request Submission and Status, HEDIS Scores</p>	<p style="text-align: center;">https://provider.molinahealthcare.com/Provider/Login</p>
<p>Behavioral Health Services (Medicaid, CHIP & MMP) Crisis Hotline Behavioral Health Services</p>	<p style="text-align: center;">(800) 818-5837 (866) 449-6849</p>
<p>Contracting (Medicaid, CHIP & MMP) How to join the network Contract Clarifications Fee Schedule Inquiries</p>	<p style="text-align: center;">Texasexpansioncontracting@molinahealthcare.com</p>
<p>Provider Complaints and Appeals (Medicaid, CHIP & MMP)</p>	<p>Phone: (866) 449-6849/ Fax: (877) 319-6852 Molina Healthcare of Texas Attn: Provider Complaints & Appeals P.O. Box 165089 Irving, Texas 75016</p>
<p>Electronic Claims Submission Vendors (Medicaid, CHIP & MMP) Availity, Zirmed, Practice Insight, SSI & Change Healthcare</p>	<p style="text-align: center;">Payor Identification for All: 20554</p>
<p>Paper & Corrected Claims (Medicaid, CHIP & MMP)</p>	<p>P.O. Box 22719 Long Beach, CA 90801</p>
<p>Pharmacy (Medicaid, CHIP & MMP) Prior Authorizations, Assistance/Inquiries</p>	<p>(866) 449-6849 (Voice) (888) 487-9251 (Fax)</p>
<p>24-hour Nurse Advice Line (Medicaid, CHIP & MMP) Clinical Support for Members</p>	<p>(888) 275-8750 (English) (866) 648-3537 (Spanish)</p>
<p>STAR+PLUS Service Coordination</p>	<p>(866) 409-0039</p>
<p>LTSS Rate Grid</p>	<p style="text-align: center;">www.MolinaHealthcare.com</p>
<p>Member Services (Medicaid & CHIP)</p>	<p>(866) 449-6849 (877) 319-6826 (CHIP Rural Service Area)</p>
<p>Enrollee Services (MMP)</p>	<p>(866) 856-8699</p>
<p>Medicaid Managed Care Helpline</p>	<p>(866) 556-8989</p>
<p>Compliance/Anti-Fraud Hotline (Medicaid, CHIP & MMP)</p>	<p>(866) 655-4626 https://molinahealthcare.alertline.com</p>

Introduction

Background

Molina Healthcare of Texas (Molina) is a for-profit corporation in the State of Texas, and a subsidiary of Molina Healthcare, Inc. Molina Healthcare, Inc. (MHI) is a publicly traded, multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. The parent company's operations are based in Long Beach, California. MHI was incorporated in the state of Delaware.

MHI was founded in 1980 by C. David Molina, M.D. as a provider organization serving the Medicaid population through a network of primary care clinics in California. In 1994, Molina Healthcare of California received its license as a health maintenance organization and began operating as a health plan. Over the past several years, MHI has expanded its operations into multiple states. MHI now touches the lives of approximately 1.8 million Medicaid members in 10 different states.

Continuing the Vision

Molina has taken great care to become an exemplary organization caring for the underserved by overcoming the financial, cultural and linguistic barriers to healthcare, thus ensuring that medical care reaches all levels of our society. We are committed to continuing our legacy of providing accessible, quality healthcare to the children and families in our communities.

Vision Statement

Molina Healthcare is an innovative healthcare leader providing quality care and accessible services in an efficient and caring manner.

Core Values

We strive to be an exemplary organization;
We care about the people we serve and advocate on their behalf;
We provide quality service and remove barriers to healthcare;
We are healthcare innovators and embrace change quickly;
We respect each other and value ethical business practices;
We are careful in the management of our financial resources and serve as prudent stewards of the public's funds;

Objectives of Program(s)

The objectives of the **STAR** and **STAR+PLUS** programs are to:

- Promote a system of health care delivery that provides coordinated and improved access to comprehensive health care and enhanced provider and client satisfaction;
- Improve health outcomes by ensuring the quality of health care provided to members and by promoting wellness and prevention;
- Achieve cost effectiveness without compromising access and quality;
- Integrate acute and long-term care services for the STAR+PLUS members;
- Coordinate Medicare services for STAR+PLUS members who have SSI-Medicare and Medicaid; and
- Provide timely claims payment.

The objectives of the **CHIP** program are to:

- Raise awareness of the children's health insurance options available in the State;
- Increase the number of insured children within the state; and
- Decrease the cost of health care by utilizing comprehensive and preventative care.

The objectives of the **Molina Dual Options STAR+PLUS MMP (MMP)** program are to:

- Provide quality healthcare coverage and services with little out-of-pocket costs for individuals who are eligible for both Medicare (entitled to benefits under Medicare Part A and enrolled under Medicare Part B and D) and full Medicaid;
- Promote a fully integrated approach in which all Medicare and Medicaid services are provided through a single managed care organization; and
- Provide appropriate services, coordinate health care and facilitate enhanced communication to improve quality management of services and health outcomes.

Role of Primary Care Provider (STAR, STAR+PLUS, & CHIP)

Primary Care Providers (PCP) participating in the Texas Medicaid and CHIP Programs practice the "medical home concept." The providers in the medical home are knowledgeable about the individual's and family's specialty care and health-related social and educational needs and are connected with necessary resources in the community that will assist the family in meeting those needs. When referring for consultation to specialists, network facilities and contractors, and/or health and health-related services, the medical home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism, and accepts them back into the medical home for continuing primary medical care and preventive health services.

Role of Specialty Care Provider (STAR, STAR+PLUS, & CHIP)

The specialty care provider coordinates care with the member's PCP through the submission of consultation letters and recommendations for inclusion in the member's medical record. This includes the coordination, documentation and communication of all physical medicine and behavioral health care on behalf of members. Specialty care providers maintain regular hours of operation that are clearly defined and communicated to members and provide urgent specialty care appointments within 24 hours of request.

Specialist as a PCP (STAR, STAR+PLUS, & CHIP)

Specialty Providers who agree to provide the full range of required primary care services may be designated by Molina as a PCP for Members in a Nursing Facility and or Members with disabilities, special health care needs, Chronic or Complex disabling or life-threatening illnesses or conditions. Upon request by a Molina Member or provider, Molina shall consider whether to approve a specialist to serve as a Member's PCP. The criteria for a specialist to serve as a PCP includes:

- whether the Member has a chronic, disabling, or life-threatening illness
- whether the requesting specialist has certified the medical need for the Member to utilize the non-PCP specialist as a PCP;
- whether the specialist is willing to accept responsibility for the coordination of all of the Member's health care needs;
- whether the specialist meets Molina requirements for PCP participation, including credentialing; and
- whether the contractual obligations of the specialist are consistent with the contractual obligations of Molina PCPs.

For further information about Molina's policy on the process for a specialist to serve as a Member's PCP, please contact Member Services.

Role of Long-Term Services & Supports (LTSS) Providers for STAR+PLUS Members and MMP Enrollees

The provider is responsible for contacting the care coordinator to extend services beyond the initial authorization period. The provider must complete a re-authorization form and send it to Molina Healthcare for re-authorization. The provider must verify member eligibility on a monthly basis.

All LTSS Providers must obtain a prior authorization before providing services to an eligible member or prior to admitting an eligible member to their facility. All Skilled Nursing Facilities must submit a Resident Transaction Notice to the State Claims Administrator within 72 hours of an admission or discharge of a STAR+PLUS member.

Role of Molina Service Coordinator for STAR+PLUS Members and MMP Enrollees

Service Coordination is a special program offered by Molina Healthcare to help members manage their health, long-term, and behavioral health care needs.

Molina will furnish a Service Coordinator to all STAR+PLUS Members and MMP Enrollees who request one. Molina will also furnish a Service Coordinator to a

STAR+PLUS Member when Molina determines one is required through an assessment of the Member's health and support needs.

The Service Coordinator will work as a team with the PCP to coordinate all Covered Services and any applicable Non-capitated Services.

Service Coordinators Role:

- Review assessments and develop a plan of care utilizing input from the member, family and providers for Level 1,2 and 3 Members
- Coordinate with the member's PCP, specialists and providers to ensure the member's health and safety needs are met in the least restrictive setting
- Refer members to support services such as disease management and community resources
- Authorize services
- Discharge Planning
- Transition Plan

Role of CHIP Perinatal Provider

It is the role of CHIP PCPs and Perinatal Care Providers to coordinate services for Members, including coordination with essential public health services such as:

- Reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization;
- Referring communicable disease outbreaks to the local Public Health Entity;
- Referring to the local Public Health Entity for Tuberculosis investigation, evaluation, and preventive treatment of persons whom the member has come into contact;
- Referring to the local Public Health Entity for STD/HIV contact investigation, evaluation, and preventive treatment of persons whom the member has come into contact;
- Coordinating care for suspected or confirmed cases of lead exposure;
- Coordinating care for the health and well-being of the unborn baby and pregnant mother; and
- Coordinating care for CHIP members to ensure they receive the most appropriate care in the most appropriate setting.

Role of Pharmacy (STAR, STAR+PLUS, MMP & CHIP)

Pharmacy Roles and Responsibilities:

- Adhere to the Formulary Preferred Drug List (PDL);
- Coordinate with the prescribing physician.
- Ensure Members receive all medications for which they are eligible; and
- Coordinate of benefits when a Member also receives Medicare Part D services or other insurance benefits.

Role of Main Dental Home

Dental plan Members may choose their Main Dental Homes. Dental plans will assign each Member to a Main Dental Home if he/she does not timely choose one. Whether chosen or assigned, each Member who is 6 months or older must have a designated Main Dental Home

A Main Dental Home serves as the Member's main dentist for all aspects of oral health care. The Main Dental Home has an ongoing relationship with that Member, to provide comprehensive, continuously accessible, coordinated, and family-centered care. The Main Dental Home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists can serve as Main Dental Homes.

Hospital Responsibilities (STAR, STAR+PLUS, & CHIP)

Molina has contracted with area hospitals to provide services to Molina Healthcare members. Hospitals must:

- Notify the PCP immediately, or no later than close of business the next business day, after a Member's appearance in an Emergency room;
- Obtain Prior authorization for inpatient and outpatient services;
- Obtain authorization for services listed in the section "What Requires Pre-Authorization;" and
- Notify Molina of all emergency admissions upon the close of the next business day.

Network Limitations (i.e. PCPs, Specialists, OB/GYN) (STAR, STAR+PLUS, & CHIP)

Molina prefers that a Pediatrician, General Practice, Family Practice, Family Advanced Practice Nurse or Physician's Assistant under the supervision of a physician act as the PCP for children. In addition, if an internist accepts the responsibility of being the PCP for a person under 20, the internist must have hospital admitting privileges to the pediatric unit.

Adults may choose from among the following specialties for their PCPs: General Practice, Family Practice, Internal Medicine, Family Advanced Practice Nurses and Physician Assistants practicing under the supervision of a physician, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHC), and similar community clinics.

A family practitioner will only be allowed to serve as an OB/GYN if he/she is board certified, is actively practicing with hospital privileges at a network hospital and has been credentialed as both a family practitioner and an OB/GYN.

Provider Advisory Groups

Providers are welcomed to participate in Molina's Provider Advisory Group. The Provider Advisory Group meets quarterly and gives providers an opportunity to share feedback and suggestions with Molina. If you are interested in joining the Advisory Group, contact your Provider Services Representative.

Chapter 1 - Benefits and Covered Services

Texas Health Steps Services (THSteps) (STAR)

Texas Health Steps is the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). The program is designed to improve the health of Texas kids. For full information on the Texas Health Steps and Comprehensive Care Program, including private duty nursing, prescribed pediatric extended care centers, and therapies, please see the Texas Medicaid Provider Procedures Manual at:

www.tmhpc.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

Timely Medical Checkups

- Checkups received before the periodic due date are not timely medical checkups.
- For reporting periods on and after September 1, 2010:
 - Member is less than 36 months of age: A checkup is considered to have been provided timely if the checkup occurs within 60 days beyond the periodic due date based on an Existing Member's birthday.
 - Member is 36 months of age or older: A checkup is considered to have been provided timely if the checkup occurs within 364 calendar days after the child's birthday in a non- leap year or 365 calendar days after the child's birthday in a leap year.

If a provider has documentation that a member has already received a checkup there will be no need to conduct another checkup until the next checkup is due whenever appropriate.

Children of Migrant Farm Workers

Children of Migrant Farm workers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

Who Can Perform THSteps Examinations?

Only Medicaid-enrolled THSteps providers will be reimbursed for performing THSteps examinations. All THSteps enrolled PCP's are encouraged to perform THSteps examinations; however, any provider enrolled as a THSteps provider may perform THSteps medical examinations. If the PCP performing the examination is not the Member's PCP, the performing provider must provide a report to the PCP of record. If the performing PCP diagnoses a medical condition that requires additional treatment, the patient must be referred back to the PCP of record

How Do I Become a THSteps Provider?

If a provider wishes to become a THSteps provider, he/she can go to www.tmhp.com and click on Provider Enrollment. This page will allow providers to complete the THSteps Enrollment Application, as well as other applications such as the Dental Provider Enrollment Application and the Children with Special Healthcare Needs (CSHCN) Provider Enrollment Application. If you have any questions, please contact TMHP at (800) 925-9126, Option 2. Completed applications should be mailed to the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin, Texas 78720-0795

Documentation of Completed Texas Health Steps Components and Elements

Each of the six components and their individual elements according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual must be completed and documented in the medical record.

Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

THSteps checkups are made up of six primary components. Many of the primary components include individual elements. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

- **Comprehensive health and developmental history** which includes nutrition screening, developmental and mental health screening and TB screening
 - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
- **Comprehensive unclothed physical examination** which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening
 - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.

- **Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
 - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP “Recommended Childhood and Adolescent Immunization Schedule-United States,” unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
 - The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
 - Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
 - Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit <https://www.dshs.texas.gov/immunize/tvfc/>.
- **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia
 - **Newborn Screening:** Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member’s mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
 - Anemia screening at 12 months.
 - Dyslipidemia Screening at 9 to 12 years of age and again 18-20 years of age
 - HIV screening at 16-18 years
 - Risk-based screenings include:
 - dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.
- **Health education** (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.
- **Dental referral** every 6 months until the parent or caregiver reports a dental home is established.
 - Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

Use of the THSteps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Their use is optional and recommended. Each checkup form includes all checkup components, screenings that are required at the checkup and suggested age

appropriate anticipatory guidance topics. They are available online in the resources section at www.txhealthsteps.com.

Information concerning the appropriate ages for lead testing, development assessment, and dental referral can be found on the Texas Department of State Health Services website.

THSteps medical checkups may be billed electronically or on a CMS-1500 claim form. Providers may request information about electronic billing or the claim form by contacting Provider Services (855) 322-4080.

Reminder: A complete checkup is a screening provided in accordance with mandated procedures and the narrative standards outlined for each procedure in the *Texas Medicaid Provider Procedures Manual - Texas Health Steps*. Incomplete medical checkups are not reimbursed.

If a member fails to keep their Texas Health Steps (THSteps) appointment, the provider office is to contact Maximus directly to report the missed appointment. Maximus can be contacted via phone at 1-877-THSteps (847-8377), Monday to Friday, 8 a.m. – 6 p.m.

Reimbursement

Reimbursement is based on the Medicaid Fee schedule and includes payment for tuberculosis (TB) skin tests and collecting the blood specimens for all required laboratory services included on the checkup periodicity schedules. Immunizations, TB skin test and supplies, laboratory supplies, and laboratory testing are made available free of charge to screening providers through DSHS. A \$5 reimbursement is made for each immunization administered during the medical checkup visit. Combined antigen vaccines (for example, DTaP and MMR) are reimbursed as one dose. The reimbursement is not made for performing the TB skin test.

In accordance with current federal policy, the Texas Medicaid Program and clients eligible for Medicaid cannot be charged when a client does not keep an appointment. Only services provided are considered for reimbursement.

Adult Accompaniment to Medical Checkup

THSteps policy requires, as a condition for provider reimbursement, that a child younger than age 15 must be accompanied by the child's parent, guardian, or other authorized adult during visits or checkups under the state Medicaid program.

Exception: School health clinics, Head Start programs, and child care facilities are exempt from this policy if the clinic, program, or facility encourages parental involvement and obtains written consent for the services. The consent from the child's parent or guardian must have been received within the one-year period before the date the services are provided and must not be revoked.

Environmental Lead Investigation (ELI) – Lead Screening and Testing

Texas Health Steps requires blood lead screening at the ages noted on the THSteps Periodicity Schedule. The screening must be performed as part of the medical checkup. Additionally, environmental lead risk assessments should be completed for any child between 24 months and 6 years with no record of a previous blood lead screening test. Providers may use the Lead Risk Questionnaire, Form Pb-110, which is provided at: <https://www.dshs.state.tx.us/THsteps/forms.shtm> or an equivalent form of their choice.

Texas law requires all blood levels, elevated and non-elevated, for members who are 14 years of age or younger be reported the Texas Childhood Lead Poisoning Prevention Program (TXCLPPP). Reports should include all information as required on the Child Blood Lead Reporting, Form F09-11709 or the Pb-111 Point-of-Care Blood Lead Testing Report form. These forms can be found at: <https://www.dshs.texas.gov/lead/Forms.aspx>.

Additional information, including follow up testing and care information and Centers for Disease and Control and Prevention guidelines can be found at: <https://www.dshs.state.tx.us/lead/child.shtm>.

Oral Evaluation and Fluoride Varnish Benefit (OEFV)

OEFV is a THSteps covered benefit. This benefit may be rendered and billed by certified Texas Health Steps providers when performed on the same day as the Texas Health Steps medical checkup. This benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, Dental anticipatory guidance, and referral to a dental home.

The visit is billed in conjunction with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier. The provider must document all components of the OEFV on the appropriate documentation. The provider should assist members with a referral to a dentist to establish a dental home whenever appropriate and maintain record of such referral in the member's record.

Newborn Examination

Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.

Any provider attending the birth of a baby must require testing for PKU, galactosemia, hypothyroidism, sickle hemoglobin and congenital adrenal hyperplasia on all newborns before discharge as required by Texas Law. All infants must be tested a second time at one to two weeks of age.

These tests must be submitted to the DSHS Laboratories. For complete information, collection testing materials, supplies, instructions and newborn screening forms contact:

DSHS Laboratories
1100 West 49th St. Austin, Texas 78756-3199
1-512-458-7331

You may also go to their link at www.dshs.state.tx.us/lab

Inpatient newborn examinations billed with procedure codes 99460, 99461, or 99463 may be counted as THSteps medical checkups when all required components are completed.

The required components of the initial THSteps checkup must meet AAP recommendations and must include the following documentation:

- The expected required components of a medical checkup must be age-appropriate and include the following:
 - Comprehensive health and developmental history including:
 - Nutrition screening
 - Developmental screening
 - Mental health
 - Tuberculosis screening
- Comprehensive unclothed physical examination, including graphic recording of measurements, including:
 - Height/length and weight
 - Body mass index (BMI) calculated beginning at 2 years of age
 - Fronto-occipital circumference through the first 24 months of age
- Blood pressure beginning at 3 years of age
- Sensory screening
- Vision screening
- Hearing screening
- Immunizations Status
- Administration, as necessary
- Laboratory testing
- Anemia screening
- Blood lead screening at 12 and 24 months
- Age-appropriate laboratory testing
- Risk-based laboratory testing
- Dental referral
- Health Education including anticipatory guidance

Include and document these components if procedure codes 99460, 99461 or 99463 are billed to Molina.

If the provider chooses to do a brief examination (not including all the above components), the provider may bill the HCPCS code 1-99431 or 1-99432 with modifier 52, which will not count as a THSteps checkup.

Providers billing these codes are not required to be THSteps providers, but they must be enrolled as Medicaid providers. Molina encourages THSteps enrollment for all providers who will be following the child for well-child care, immunizations, and offering a “medical home” for the child. Physicians and hospital staff are encouraged to inform parents eligible for Medicaid that the next THSteps checkup on the periodicity schedule should be scheduled at one to two weeks of age and that regular checkups should be scheduled during the first year.

THSteps Benefits and Limitations

Medical checkup services are covered for members younger than age 21 years when delivered in accordance with the periodicity schedule. The periodicity schedule specifies the screening procedures recommended at each stage of the member's life and identifies the time period, based on the client's age, when medical checkup services are reimbursable.

In acknowledgment of the practical situations that occur in the office or clinic settings, the periodicity schedule stresses the philosophy that the components of the THSteps medical checkup should be completed according to the individual child's appropriate needs. If a component cannot be completed because of a medical contraindication of child's condition, then a follow-up visit is necessary.

Member eligibility for a medical checkup is determined by the Member's age on the first day of the month. If a Member has a birthday on any day except the first day during the month, the new eligibility period begins on the first of the following month. If a Member turns age 21 years during a month, the Member continues to be eligible for THSteps services through the end of that month.

If components of the THSteps checkup have been provided one month preceding the child's birthday month and the medical checkup occurs in the following month, providers should clearly refer to that previous documentation, including the date(s) of service in the current clinical notation, and add appropriate new documentation for the checkup currently being billed.

All components of the THSteps medical checkup are included in the reimbursement of the visit. The visit is a comprehensive medical checkup and must include all assessments, screenings, and laboratory tests as indicated on the periodicity schedule. Specifically, when there is an available CPT code for a component, it will not be reimbursed separately on the same day as a medical checkup.

Immunizations – Medicaid and CHIP

Providers who administer THSteps immunizations must comply with the Immunization Standard Requirements set forth in Chapter 161, Health and Safety Code; the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule; the AAP Periodicity Schedule for CHIP Members; and the Texas Health Steps Periodicity Schedule for Medicaid Members.

The Texas Vaccines for Children (TVFC) Program provides Medicaid and CHIP children who are younger than age 19 years with vaccines that are routinely recommended according to the Recommended Childhood Immunization Schedule (Advisory Committee on Immunization Practices ACIP, American Academy of Pediatrics AAP, and the American Academy of Family Physicians AAFP). If not already enrolled, Medicaid and CHIP providers can enroll, as applicable, as Texas Vaccines for Children Providers

Medicaid members under age 20 must be immunized during the THSteps checkup according to the ACIP routine immunization schedule. The screening provider

is responsible for administration of immunizations and should not refer children to local health departments to receive the immunizations. Combined antigens are reimbursed as one immunization.

Reminder: An administration fee is paid for each immunization given during a THSteps checkup or as part of a follow-up claim, except for services performed in an FQHC or RHC setting.

For children not previously immunized, DSHS requires immunizations be given unless medically contraindicated or excluded from immunizations for reasons of conscience, including a religious belief.

It is important for all immunizations to be properly documented in the member's medical record. Immunizations are a required component of the THSteps medical checkup for Medicaid members. Immunizations administered during a checkup must be indicated on the claim.

ImmTrac is a central repository of a child's (younger than 18 years) immunization record. It is a free service offered to medical providers, parents, public health authorities, schools, and licensed child-care facilities. Texas law requires that medical providers report to ImmTrac any vaccines administered to children younger than age 18 years whose parents have consented in writing to participate in the registry.

Medicaid Covered Benefits for STAR and STAR+PLUS

Molina covers all medically necessary Medicaid covered services with no pre-existing condition limitations. Some services require prior authorization. For the most updated list of Medicaid covered benefits for STAR and STAR+PLUS, including limitations and exclusions, please refer to refer to the ***Texas Medicaid Provider Procedures Manual***, which can be accessed online at: <http://www.tmhp.com>. For Molina prior authorization guidelines please refer to the Prior Authorization Review Guide available at Molinahealthcare.com.

Early Childhood Intervention (ECI)

The Texas Interagency Council on Early Childhood Intervention (ECI) was established in 1981 to develop a statewide system of comprehensive services for infants and toddlers with developmental disabilities. ECI serves children, 35 months of age and younger, (i.e., before their third birthday), with disabilities or delays and supports families to help their children reach their potential through education and developmental services.

ECI provides evaluations and assessments, at no cost to families, to determine eligibility and need for services. Families and professionals work as a team to plan appropriate services based on the unique needs of the child and family.

Providers are required, under Federal and State law, to:

- Screen/ identify Members 35 months of age or younger suspected of having a developmental delay or disability, or who are at risk of delay, and children who have suspected or confirmed hearing and/or visual impairment.

- Refer identified members to the Texas Early Childhood Intervention program for assessment and evaluation as soon as possible, but no longer than seven (7) days after identifying a disability or suspected delay in development. Referrals can be based on professional judgment or a family's concern. A medical diagnosis or a confirmed developmental delay is not required for referrals.
- Use materials from Department of Assistive and Rehabilitative Services (DARS) available on: <http://www.dars.State.tx.us/ecis/index.shtml>
- With parent's consent, participate in the development and implementation of the Individual Family Service Plan (IFSP) including the provision of services and diagnostic procedures necessary to develop and carry out the plan.
- Comply with the release of records within 45 days so that screening may be completed.

Early identification will facilitate the development of an effective treatment plan that may prevent or reduce a disability that may last a lifetime.

Parents/Guardians of children between the ages of 0 – 35 months with a disability or suspected delays in development, or children who have suspected or confirmed hearing and/or visual impairment should be referred to the ECI DARS Inquiries Line (800) 628-5115.

Comprehensive Care Program (CCP)

Comprehensive Care Program (CCP) is Texas' name for the expanded portion of Texas Health Steps. CCP covers services for children birth through 20 years old that are not usually allowed or are more limited under Medicaid for the adult population. CCP is a result of a Congressional mandate that took effect in 1990.

Federal changes made in the Omnibus Reconciliation Act of 1989 (OBRA 89) expanded Medicaid services and Texas Health Steps in particular. Under OBRA 89, children 20 years old and younger are eligible for any medically necessary and appropriate health care service that is covered by

Medicaid, regardless of the limitations of the state's Medicaid Program. Texas Health Steps-CCP services include benefits which were not available to children before OBRA 89, such as:

- Treatment in freestanding psychiatric hospitals
- Developmental speech therapy
- Developmental occupational therapy
- Augmentative Communication Devices/Systems
- Private Duty Nursing

Pediatric Therapies

Prior authorizations for pediatric speech, physical and occupational therapy are required for all requests after the initial evaluation. The code appropriate codes for these authorizations can be found on the Prior Authorization Code Matrix on MolinaHealthcare.com.

Most CCP services require prior authorization. See prior authorization guidelines for further information.

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A Member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services and must be coordinated to prevent duplication. A Member may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the Member's medical condition or the authorized hours are not commensurate with the Member's medical needs. Per 1 Tex. Admin. Code §363.209 (c)(3), PPECC services are intended to be a one-on-one replacement of PDN hours unless additional hours are medically necessary.

Drug Benefits (STAR, STAR+PLUS & CHIP)

Medically necessary outpatient drugs and biologicals; including pharmacy-dispensed and provider administered outpatient drugs and biologicals are covered benefits for STAR, STAR+PLUS and CHIP members.

Emergency Prescription Supply (STAR, STAR+PLUS, & CHIP)

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PS), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- "8" in "Prior Authorization Type Code" (Field 461-EU)
- "801" in "Prior Authorization Number Submitted" (Field 462-EV)
- "3" in "Days Supply" (in the Claim segment of the billing transaction (Field 405-D5))
- The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber.

Call (866)449-6849 for more information about the 72-hour emergency prescription supply policy.

CHIP Member Prescriptions

CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

Additional Benefits to STAR+PLUS Members and MMP Enrollees

STAR+PLUS members receive all the benefits of the traditional Texas Medicaid program. The provider must bill Molina Healthcare for Inpatient Behavioral Health Services. Additional benefits obtained through the STAR+PLUS program are:

- Unlimited medically necessary prescription drugs for STAR+PLUS Medicaid-only members not covered by Medicare.
- Value-Added Services
- Long-Term Care Covered Services

\$200,000 annual limit on inpatient services does not apply for adult STAR and STAR+PLUS Members.

Service Coordination STAR+PLUS Members and MMP Enrollees

Service Coordination is a special program offered by Molina Healthcare to help members manage their health, long-term and behavioral health care needs.

Molina will furnish a Service Coordinator to all STAR+PLUS Members/MMP Enrollees who request one. Members may request a Service Coordinator by calling (866) 409-0039. Molina will also furnish a Service Coordinator to a STAR+PLUS Member when Molina determines one is required through an assessment of the Member's health and support needs.

Molina will ensure that each STAR+PLUS Member/MMP Enrollee has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, services as a central point of integration and coordination of Covered Services, including primary, Acute Care, Long-term Services and Supports, and Behavioral Health Services.

The Service Coordinator will work as a team with the PCP to coordinate all STAR+PLUS Covered Services and any applicable Non-capitated Services.

Service Coordinators Role/Services:

- Review assessments and develop plan of care utilizing input from the member, family and providers for Level 1, 2 and 3 Members
- Coordinate with the member's PCP, specialists and other providers to ensure the member's health and safety needs are met in the least restrictive setting
- Refer members to support services such as disease management and community resources
- Authorize services
- Discharge Planning – the service coordinator will work with the member's PCP, the hospital, inpatient psychiatric facility, or Nursing Facility discharge planners, the

attending physician, the Member, and the member's family to assess and plan for the member's discharge.

- Transition Planning – review of existing care plans prepared by HHSC or another STAR+PLUS MCO, preparation of a transition plan that ensures continuous care during the member's transfer from one MCO to another (reviewing and/or supplying a current care plans and names of current providers), ensure Member receives the necessary supportive equipment without undue delay if durable medical equipment or supplies has been ordered prior to enrollment but have not been received by the time of enrollment, and ensure payment to the existing provider of service under the existing authorizations for up to six months, until the new MCO has completed the assessment and Service Plans and issued new authorizations.

All care coordinator staff members can assist with basic inquires. If additional follow up is needed, the assigned Service Coordinator will contact the provider or member within 24 hours. To contact Molina's care coordinator team call (866) 409-0039.

Level 1 – Health Management

Health Management is focused on disease prevention and health promotion. It is provided for members/enrollees 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 an increased risk for future health problems and compromise independent living. The goal of Health Management is to achieve member/enrollee wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation throughout the continuum of care.

At this level, members/enrollees 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/Enrollees 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/enrollees who have medium-risk chronic illness requiring ongoing intervention. These services are designed to improve the member's/enrollee'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/enrollee's unique health needs, create individualized care plans with prioritized goals, and facilitate services that minimize barriers to care for optimal health outcomes.

Case Managers have direct telephonic access with members/enrollees. In addition to the member/enrollee, 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/enrollee, the Care Manager may enlist the help of a Community Health Worker or Community Connector to meet with the member/enrollee in the community for education, access or information exchange.

Level 3 – Complex Case Management

Complex Case Management is provided to members/enrollees 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/enrollees improve functional capacity and regain optimum health in an efficient and cost-effective manner. Comprehensive assessments of member/enrollee 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.

Medicaid Program Limitations and Exclusions (STAR & STAR+PLUS)

Molina Healthcare will not pay for services that are not covered by Medicaid. The following is a list of services that are not covered, this list is not all-inclusive:

- All services or supplies not medically necessary
- Services or supplies received without following the directions in this handbook
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid
- Organ transplants that are not covered by Medicaid
- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Infertility services, including reversal of voluntary sterilization procedures
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure
- Cosmetic surgery that is not medically necessary
- Shots (immunizations) for travel outside the United States
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services are covered)
- Services for treatment of obesity unless determined medically necessary
- Custodial or supportive care
- Sex change surgery and related services
- Sexual or marriage counseling
- Court ordered testing
- Educational testing and diagnosis
- Acupuncture and biofeedback services
- Services to find the cause of death (autopsy)
- Comfort items in the hospital, like a television or telephone
- Paternity testing

Long Term Care providers participating in rate enhancements will receive rate enhancement payments included in rate according to level.

Spell of Illness Limitation STAR+PLUS Only

The spell of illness limitation applies to clients in the STAR+PLUS Program. It does not apply for STAR members. A spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

An individual may be discharged from and readmitted to a hospital several times, regardless of the admittance reasons, and still be considered to be in the same spell of illness if 60 days have not elapsed between discharge and readmission. The following are exceptions to the spell of illness limitation:

- A prior-approved solid organ transplant has an additional 30-day spell of illness, which begins on the date of the transplant.
- No spell of illness limitation exists for THSteps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.
- The client is enrolled in the Medicaid managed care STAR program.

STAR+PLUS Covered Services

Long Term Support Services

- Personal Assistant Services (PAS): provides in-home assistance to individuals as identified and authorized on his/her individual service plan with the performance of activities of daily living, household chores, and nursing tasks that have been delegated by a registered nurse (RN).
- Day Activity and Health Services (DAHS): includes nursing and personal care services, physical rehabilitative services, nutrition services, transportation services, and other supportive services as identified and authorized on the member's individual service plan. These services are given by facilities licensed by Health and Human Services (HHSC).
- Home and Community Based Services (HCBS) for STAR+PLUS Waiver Services
- Employment Assistance (Effective September 1, 2014)
- Supported Employment (Effective September 1, 2014)
- Cognitive Rehabilitation Therapy (Effective March 6, 2014)
- Adult Foster Care
- Financial management Services
- Support Consultation
- Medical Supplies
- Dental Services
- Targeted Case management (Effective September 1, 2014)
- Mental Health Rehabilitative Services (effective September 1, 2014)
- Intellectual Developmental Disability

Medicaid for Breast Cancer and Cervical Cancer (MBCC) Program

MBCC provides Medicaid to women diagnosed with breast or cervical cancer or certain pre-cancer conditions.

Effective September 1, 2017, women enrolled in the MBCC program will be eligible for the full array of Medicaid benefits and covered services, including cancer treatment, through the STAR+PLUS Medicaid Managed Care Program.

Please refer to TMHP for a more inclusive listing of limitations and exclusions that apply to each benefit category.

Supported Employment Services

Supported Employment (SE) services provide assistance to the member, as authorized on Form H1700-1, Member Service Plan — SPW (Pg. 1), to help a member sustain competitive employment or self-employment.

Competitive employment is work:

- in the competitive labor market, in which anyone may compete for employment, that is performed on a full-time or part-time basis in an integrated setting; and
- for which a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by members without disabilities.¹

An integrated setting is a setting typically found in the community in which applicants or eligible members interact with people without disabilities, other than service providers, to the same extent that people without disabilities in comparable positions interact with other people without disabilities. An integrated setting does not include a setting in which:

- groups of people with disabilities work in an area that is not part of the general workplace where people without disabilities work; or
- a mobile crew of people with disabilities work in the community.²

Self-employment is work in which the member:

- Solely owns, manages, and operates a business;
- Is not an employee of another person or entity, business; and
- Actively markets a service or product to potential customers.³

Description of Supported Employment Services

- Assistance provided as an HCBS STAR+PLUS Waiver service, in order to sustain paid employment, to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which members without disabilities are employed. SE includes employment adaptations, supervision, and training related to a member's diagnosis.
- The managed care organization (MCO) must ensure provision of SE, as needed, for a STAR+PLUS Waiver (SPW) member to sustain competitive employment or self-employment, if the services are not available through the local school district for a member under age 22.

¹This definition is consistent with 34 CFR 361.5(b)(11).

²This definition is consistent with 34 CFR 361.5(b)(33).

³This definition is consistent with the Department of Assistive and Rehabilitative Services' (DARS) Community Rehabilitation Program Standards for Providers (www.dars.state.tx.us/drs/providermanual/).

Supported Employment may be provided through the SPW if documentation is maintained in the member's record, for a member under age 22, that the service is not available to the member under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).

Supported Employment Activities

SE services consist of developing and implementing strategies for achieving the member's desired employment outcome. Services are individualized, person-directed, and may include the following activities:

- orienting and training the individual on work-related tasks;
- training or consulting with employers, co-workers, or advocates to maximize natural supports;
- monitoring job performance;
- communicating with managers and supervisors to gather input and plan training;
- communicating with company personnel or support systems to ensure job retention;
- training in work-related tasks or behaviors to ensure job retention (for example, grooming or behavior management);
- setting up compensatory strategies;
- reporting earned income to Social Security Administration and the Texas Health and Human Services Commission;
- developing the individual's transportation plan;
- training the individual on how to travel to and from the job;
- securing transportation for or transporting an individual as necessary to assist the person to sustain the job;
- assisting the individual to utilize work incentives and continue to access needed supports and services;
- assisting the individual with career advancement; and
- assisting the individual to develop assets and obtain self-sufficiency through work.

For self-employment, services may additionally include the following activities:

- training or consulting in work-related tasks or behaviors such as support for advertising, marketing, and sales;
- training or consulting with paid or natural supports (accountants, employees, etc.) who are supporting the individual either short-term or long-term in managing the business;
- problem-resolution related to company personnel or support systems necessary to run the business effectively and efficiently; and
- assistance with bookkeeping, marketing, and managing data or inventories.

Qualifications of Supported Employment Providers

A SE provider must satisfy one of these options:

Option 1:

- a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- six months of documented experience providing services to people with disabilities in a professional or personal setting.

Option 2:

- an associate's degree in rehabilitation, business, marketing, or a related human services field; and
- one year of documented experience providing services to people with disabilities in a professional or personal setting.

Option 3:

- a high school diploma or GED, and
- two years of documented experience providing services to people with disabilities in a professional or personal setting.

The managed care organization must ensure that a provider of SE services:

(1) has not been convicted of a crime listed in Texas Health and Safety Code, §250.006;

(2) is not listed as "unemployable" in the Employee Misconduct Registry or the Nurse Aide Registry maintained by HHSC by searching or ensuring a search of such registries is conducted, before hire and annually thereafter;

(3) is not listed on the following websites as excluded from participation in any federal or state health care program:

- HHS-OIG Exclusion; and
- HHS-OIG Exclusion Search;

by searching or ensuring a search of such registries is conducted, before hire and at least monthly thereafter;

(4) is knowledgeable of acts that constitute abuse, neglect, or exploitation of a member, as defined in 40 TAC Chapter 705, Subchapter A;

(5) is instructed on how to report suspected abuse, neglect or exploitation;

(6) reports suspected abuse, neglect, or exploitation as instructed;

(7) provides transportation that adheres to applicable state laws; and

(8) is not a spouse, legally responsible person or employment supervisor of the member who receives the service.

Process to Authorize Supported Employment Services

(1) For SPW members who are competitively or self-employed, the MCO service coordinator determines if the member needs paid supports to sustain employment.

(2) If the member has received assistance with employment through DARS and requires SE through the SPW, with permission of the member, the service coordinator, along with the member, must:

- a. If possible, attend any Division of Rehabilitative Services (DRS)/Division for Blind Services (DBS) planning meetings related to the member's employment,
- b. If possible, take an active role in providing input to the DARS IPE,

- c. If the IPE designates supported employment, the MCO and member must consider including that service on the member's service plan prior to DARS closing out the member's services; and
- d. Begin providing those services and supports described in (c) approved in the member's service plan without a gap between the provision of DARS services and the SPW services.

Unit of Service

A unit of service is one hour. Providers of SE must submit claims in one hour increments. The maximum number of units that can be claimed in one day is 24 hours, although it would be highly unlikely for SE to be provided for that length of time in a single day.

Documentation Requirements

For the period of time SE is included in the member's service plan, the provider must develop and update quarterly a plan for delivering SE, including documentation of the following information:

- Name of the member
- Member's employment objectives (the anticipated benefit from the member receiving SE services);
- Strategies for achieving the member's employment objectives, including those addressing the member's employment support needs,
- Names of the people, in addition to the member, whose support is or will be needed to ensure successful employment, and the corresponding level of support those persons are providing or have committed to providing,
- Any concerns about the effect of earnings on benefits, and a plan to address those concerns,
- Progress toward the member's employment goal,
- A plan for gradually decreasing (i.e., fading) the amount of supported employment an individual receives, and
- If progress is slower than anticipated, an explanation of why the documented strategies have not been effective, and a plan to improve the member's independence on the job.

Claims Requirements

- Only providers credentialed by the MCO to provide SE may submit claims for SE services.
- The MCO must request an Atypical Provider Identification (API) number for providers of SE after the MCO has determined that all the criteria outlined in "Qualifications of Employment Assistance Providers" have been met.
- Claims are submitted using the CMS Health Insurance Claim Form 1500. For SE, field #17 (Name of Referring Provider or Other Source) is not a required field. The Health Care Common Procedures Coding System (HCPCS) code to be used for SE is H2025.

Employment Assistance Services

Employment Assistance (EA) services provide assistance to the member, as authorized on Form H1700-1, Member Service Plan — SPW (Pg. 1), to help a member locate competitive employment or self-employment.

Competitive employment is work:

- in the competitive labor market, in which anyone may compete for employment, that is performed on a full-time or part-time basis in an integrated setting; and
- for which a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by members without disabilities.⁴

An integrated setting is a setting typically found in the community in which applicants or eligible members interact with people without disabilities, other than service providers, to the same extent that people without disabilities in comparable positions interact with other people without disabilities. An integrated setting does not include a setting in which:

- groups of people with disabilities work in an area that is not part of the general workplace where people without disabilities work; or
- a mobile crew of people with disabilities work in the community.⁵

Self-employment is work in which the member:

- Solely owns, manages, and operates a business;
- Is not an employee of another person or entity, business; and
- Actively markets a service or product to potential customers.⁶

Description of Employment Assistance Services

- EA services include, but are not limited to, the following:
 - identifying a member's employment preferences, job skills, and requirements for a work setting and work conditions;
 - locating prospective employers offering employment compatible with a member's identified preferences, skills, and requirements; and
 - contacting a prospective employer on behalf of a member and negotiating the member's employment.
- The managed care organization (MCO) must ensure provision of EA as identified through use of Job Interest Assessment, to participants of the SPW if the services are not available through DARS or the local school district for members under age 22.
- EA may be provided through the SPW if documentation is maintained in the member's record that the service is not available to the member under a program funded under §110 of the Rehabilitation Act of 1973 or, for members under age 22, under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.)

Employment Assistance Activities

⁴ This definition is consistent with 34 CFR 361.5(b)(11).

⁵ This definition is consistent with 34 CFR 361.5(b)(33).

⁶ This definition is consistent with the Department of Assistive and Rehabilitative Services' (DARS) Community Rehabilitation Program Standards for Providers (www.dars.state.tx.us/drs/providermanual/).

EA services consist of developing and implementing strategies for achieving the member's desired employment outcome. Services are individualized, person-directed, and may include the following activities:

- exploring options related to wages and employment outcomes (including self-employment outcomes);
- exploring the member's interests, capabilities, preferences, and ongoing support needs;
- exploring the extended services and supports required at and away from the job site that will be necessary for employment success;
- observing the member's work skills and behaviors at home and in the community and touring current or potential work environments with the member;
- assisting the member to understand the impact of work activity on their services and financial supports;
- assisting the member to utilize work incentives;
- collecting personal and employer reference information;
- assessing the member's learning style and needs for adaptive technology, accommodations, and on-site supports;
- assessing the member's strengths, challenges, and transferable skills from previous job placements;
- identifying the member's assets, strengths and abilities;
- identifying negotiable and non-negotiable employment conditions;
- identifying targeted job tasks the member can perform or potentially perform;
- identifying potential business ideas or employers;
- writing résumés and proposals to assist in placement;
- contacting employers and developing member jobs;
- performing a job analysis;
- reviewing job match information;
- assisting the member with job applications, pre-employment forms, practice interviews, and pre-employment testing or physicals;
- accompanying the member to interviews and company visits;
- negotiating aspects of the member's employment with prospective employers;
- assisting the employer with the Work Opportunity Tax Credit and other employer benefits;
- developing the member's transportation plan;
- training the member on how to travel to and from a job;
- securing transportation for or transporting a member as necessary to assist the member to obtain a job;
- participating in service planning meetings; and
- assisting to help a member find more suitable employment.

Qualifications of Employment Assistance Providers

An EA service provider must satisfy one of these options:

Option 1:

- a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
- six (6) months of documented experience providing services to people with disabilities in a professional or personal setting.

Option 2:

- an associate's degree in rehabilitation, business, marketing, or a related human services field; and
- one (1) year of documented experience providing services to people with disabilities in a professional or personal setting.

Option 3:

- a high school diploma or GED, and
- two (2) years of documented experience providing services to people with disabilities in a professional or personal setting.

The managed care organization must ensure that a provider of employment assistance services:

- (1) has not been convicted of a crime listed in Texas Health and Safety Code, §250.006;
- (2) is not listed as "unemployable" in the Employee Misconduct Registry or the Nurse Aide Registry maintained by HHSC by searching or ensuring a search of such registries is conducted, before hire and annually thereafter;
- (3) is not listed on the following websites as excluded from participation in any federal or state health care program:
 - HHS-OIG Exclusion; and
 - HHS-OIG Exclusion Search;
- (4) is knowledgeable of acts that constitute abuse, neglect, or exploitation of a member, as defined in 40 TAC Chapter 705, Subchapter A;
- (5) is instructed on how to report suspected abuse, neglect or exploitation;
- (6) reports suspected abuse, neglect, or exploitation as instructed;
- (7) adheres to applicable state laws while providing transportation; and
- (8) is not a spouse, legally responsible person or potential employer of the member who receives the service.

Process to Authorize Employment Assistance Services

- (1) The MCO completes the Job Interest Assessment for every SPW member.
- (2) If the Job Interest Assessment indicates a "yes" response on any of the last three questions, the MCO uses the "First Steps to Employment for People with Significant Disabilities" tool to guide the member's support team, including the member, to consider the interests and strengths of, and supports available to the member before applying for DARS services.
While the tool was developed in consultation with DARS, considering these topics should help a member be successful in employment even if he or she does not receive DARS services.
- (3) The MCO refers the SPW member to DARS within 10 business days of completing the Job Interest Assessment.

- (4) If the vocational rehabilitation counselor (VRC) determines that DARS is not the appropriate resource to meet the member's needs and does not take an application for services, documentation of this decision in the member's record serves as sufficient evidence that DARS services are not available and the member is eligible to receive waiver-funded employment assistance.
- (5) Upon request and with proper authorization for disclosure, the MCO will ensure the DARS VRC is provided with copies of any of the member's records, including the following items:
 - a. The member's most recent service plan;
 - b. Any current vocational assessments or person-directed plans that focus on employment opportunities;
 - c. Any other available records pertaining to the member's health condition, including but not limited to medical, psychological, and psychiatric reports;
 - d. For DRS applicants, items described in the DARS Guide for Applicants (<http://www.dars.state.tx.us/drs/DRSguide.shtml>; for DBS, call 800-628-5115 or use the following link <http://www.dars.state.tx.us/dbs/offices/OfficeLocator.aspx?div=4> to obtain the local office number);
 - e. A copy of the member's court-ordered guardianship documents, if any guardian has been appointed; and
 - f. Contact information for the member's MCO service coordinator.
- (6) A member who has applied for DARS services is eligible to receive waiver-funded employment assistance until DARS has developed the Individualized Plan for Employment (IPE) and the member has signed it.
- (7) The member's MCO service coordinator must ensure that communication is maintained with the DARS Vocational Rehabilitation Counselor (VRC) regarding waiver-funded services provided between the DARS VR application and the "Start Date" of DARS services as defined in the member's DARS VR IPE.
- (8) If a member refuses to contact DARS, he or she may not receive waiver-funded employment assistance.
- (9) With permission of the member, the MCO service coordinator supporting a member determined eligible for DARS services, along with the member, must:
 - a. If possible, attend any Division of Rehabilitative Services (DRS)/Division for Blind Services (DBS) planning meetings related to the member's employment;
 - b. If possible, take an active role in providing input to the DARS IPE;
 - c. Review the long-term services and supports listed on the DARS IPE, and, if any of those services and supports are available through the waiver, incorporate them in a revision to the member's service plan prior to DARS' closure; and
 - d. Begin providing those services and supports described in (c) approved in the member's service plan without a gap between the provision of DARS services and the SPW services.

Unit of Service

A unit of service is one hour. Providers of EA must submit claims in one-hour increments. The maximum number of units that can be claimed in one day is 24 hours, although it would be highly unlikely for EA to be provided for that length of time in a single day.

Documentation Requirements

For the period of time employment assistance is included in the member's service plan, the provider must develop and update quarterly a plan for delivering EA, including documentation of the following information:

- Name of the member
- Member's employment goal,
- Strategies for achieving the member's employment goal, including those addressing the member's anticipated employment support needs,
- Names of the people, in addition to the member, whose support is or will be needed to ensure successful employment placement, and the corresponding level of support those persons are providing or have committed to providing,
- Any concerns about the effect of earnings on benefits, and a plan to address those concerns,
- Progress toward the member's employment goal, and
- If progress is slower than anticipated, an explanation of why the documented strategies have not been effective, and a plan improve the effectiveness of the member's employment search.

Claims Requirements

- Only providers credentialed by the MCO to provide EA may submit claims for EA services.
- The MCO must request an Atypical Provider Identification (API) number for providers of EA after the MCO has determined that all the criteria outlined in "Qualifications of Employment Assistance Providers" have been met.
- Claims are submitted using the CMS Health insurance Claim Form 1500. For EA, field #17 (Name of Referring Provider or Other Source) is not a required field. The Health Care Common Procedures Coding System (HCPCS) code to be used for EA is H2023.

Provider Requirements

- Training and certification to administer Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) assessment tools
- Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG)
- Attestation from provider entity to MCO that organization has the ability to provide, either directly or through subcontract, the Members with the full array of MHR and TCM services as outlines in the RRUMG
- HHSC established qualification and supervisory protocols

Mental Health Rehabilitative and Mental Health Targeted Case Management (TCM) Services – Managed Care Billing

The billing codes, modifiers, and rates for mental health rehabilitative and mental health targeted case management services can be found below. Please note that the Department of State Health Services (DSHS) currently requires the Local Mental Health Authorities (LMHAs) to use additional modifiers, which are not listed below. These

additional modifiers are not required for billing and will not be required to be used in Medicaid managed care. Only the modifiers listed below will be required in managed care.

Mental Health Rehabilitative Services

The following mental health rehabilitative services may be provided to individuals with a severe and persistent mental illness (SPMI) or a severe emotional disturbance (SED) as defined in the DSM-IV-TR and who require rehabilitative services as determined by either the Adults Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS) Assessment:

- Adult Day Program
- Medication Training and Support
- Crisis Intervention
- Skills Training and Development
- Psychosocial Rehabilitative Services

The following modifiers reflect Behavioral Health services and can only be billed by Mental Health providers. These must be billed with the most appropriate procedure code as indicated in the sections below:

Modifier	Description
ET	Emergency treatment
HA	Child/adolescent program
HQ	Group setting
TD	RN

Adult Day Program

Service	Procedure	Modifier 1	Modifier 2	FFS Rate	Unit
Adult Day Program for Acute Needs	G0177			\$24.32	45-60 min

Medication Training and Support

Service	Procedure Code	Modifier 1	Modifier 2	FFS Rate	Unit
Medication Training and Support	H0034			\$13.53	15 min
Group services for the adult	H0034	HQ		\$2.71	15 min

Group services for the child and adolescent (with or without other group)	H0034	HA	HQ	\$3.38	15 min
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Crisis Intervention

Service	Procedure Code	Modifier 1	Modifier 2	FFS Rate	Unit
Adult services	H2011			\$36.89	15 min
Child and Adolescent services	H2011	HA		\$36.89	15 min

Skills Training and Development

Service	Procedure Code	Modifier 1	Modifier 2	FFS Rate	Unit
Individual services for adult	H2014			\$25.02	15 min
Group services for adult	H2014	HQ		\$5.00	15 min
Individual services for the child and adolescent (with or without other individual)	H2014	HA		\$25.02	15 min
Group services for the child and adolescent	H2014	HA	HQ	\$6.26	15 min

Psychosocial Rehabilitative Services

Service	Procedure Code	Modifier 1	Modifier 2	FFS Rate	Unit
Individual services	H2017			\$26.93	15 min
Individual services rendered by an RN	H2017	TD		\$26.93	15 min
Group services	H2017	HQ		\$5.39	15 min

Group services rendered by an RN	H2017	HQ	TD	\$5.39	15 min
Individual crisis services	H2017	ET		\$26.93	15 min

Targeted Case Management

The following mental health targeted case management services may be provided to individuals with an SPMI or SED as defined in the DSM-IV-TR, who require the service as determined by either the Adults Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS) assessment:

- Case management for people who have SED (child, 3 through 17 years of age), which includes routine and intensive case management services
- Case management for people who have SPMI (adult, 18 years of age or older)

Service	Procedure	Modifier	Limitations	FFS Rate	Unit
Routine mental health targeted case management (adult)	T1017	TF	32 units (8 hours) per calendar day for clients who are 18 years of	\$19.83	15 min
Routine case management (child and adolescent)	T1017	TF, HA	32 units (8 Hours) per calendar day for clients who are 17 years of	\$24.07	15 min
Intensive case management (child and adolescent)	T1017	TG, HA	32 units (8 hours) per calendar day for clients who are 17 years of	\$31.69	15 min

Intellectual Developmental Disability (IDD)

Definition: Significantly sub-average general intellectual functioning that is concurrent with deficits in adaptive behavior that originates during the developmental period. (Formerly referred to as mental retardation)

IDD is a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

Members who would be eligible for IDD services:

- have an Intellectual Quotient (IQ) equal to or less than 75;
- have IDD and live in an Intermediate Care Facility (ICF-IDD) or IID facility; and
- receive services through the Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), and Home and Community-based Services (HCS).
- Texas Home Living (TxHmL) waivers will be enrolled in the STAR+PLUS program effective 9/1/14.
- Acute Care Services only.
- Waiver services will continue to be supplied by state.
- Texas IDD member population statewide is approximately 23,000.
- Members typically reside in a small community-based facility.

Behavioral Health and Substance Abuse Services for MMP Enrollees

The following benefits are available to Molina Dual Option STAR+PLUS MMP enrollees and are a responsibility of Molina:

- Mental Health Hospitalization
- Mental Health Outpatient Services
- Psychotropic Drugs
- Mental Health Services within the scope of a primary care physician
- Psychologists
- Psychiatrists

Molina Healthcare of Texas will:

1. Provide acute care services. (HHSC will continue to provide the long-term care services and supports LTSS, including any state plan services).
2. Provide access to MHT Member Services.
3. Provide Service Coordination services.
4. Work with the HHSC service coordinators to ensure individuals receive adequate and appropriate acute care services.
5. Provide, when requested, documentation whenever acute care services are exhausted or denied so that an identical or similar service may be provided through Long Term Services and Supports (LTSS).

Service Coordination Requirements

- MHT will work in a concerted effort to ensure services are adequate and sufficient to meet any acute care needs required by the IDD membership.
- Members will be assigned a Service Coordinator based upon zip code.
- Each MHT Service Coordinator working with the MHT IDD membership will complete a formal Qualified Intellectual Disability Professional coursework.
- Each member will receive scheduled contacts associated with their risk level:
 - Level 1: Members receive a minimum of 2 face-to-face SC contacts, annually.
 - Level 2: Members receive a minimum of 1 face-to-face and one telephonic coordination contact annually.
 - All service requests for acute care services will be reviewed and processed.

Providing Care to IDD Members

- **Acute care services** must be provided by a contracted MHT provider. If a member with IDD is established with an **out of network provider**, then the MHT **Manager**

of Provider Contracts must receive the provider's name and other information to pursue a formal contract with Molina Healthcare of Texas.

- MHT will ensure continuity of care for all new members with IDD. The member may be redirected to a contracted provider if unable to secure a formal contract with a non-contracted provider.
- MHT must notify the **primary** program **Service Coordinator** or **Case Manager** when a member with IDD has a service adverse action or has exhausted a benefit.
- The MHT Service Coordinator will attend annual IDT for service planning. The HHSC Service Coordinator or Case Manager will notify the MHT Service Coordinator of any change in condition, change in a HHSC Service Coordinator or Case Manager assignment, member change of location, or change in condition upon awareness of such changes.

Intellectual Developmental Disability Does not include:

- Individuals residing in a state supported living center;
- Dual eligibles (receiving Medicare and Medicaid); and/or
- Children and young adults under age 21 receiving SSI or SSI-related services or voluntary Cognitive Rehabilitation Therapy.

New Cognitive Rehabilitation Therapy Benefits for Home Community Based Services (HCBS) STAR+PLUS Waiver members only Effective March 1, 2014

Effective for dates of services after March 1, 2014, Molina Healthcare of Texas will authorize Cognitive Rehabilitation Therapy if one of the following Texas Medicaid-covered assessment tests, as listed in the Texas Medicaid Provider Procedures Manual, shows that the therapy can benefit the Member and is Medically Necessary:

- Neurobehavioral Test (CPT Code 96116); or
- Neuropsychological Test (CPT Code 96118).

What is CRT?

Cognitive Rehabilitation Therapy (CRT) is a benefit and service under the STAR+PLUS Waiver (SPW) program. CRT is a service that assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. CRT is provided in accordance with the developed plan of care and includes reinforcing, strengthening, or re-establishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. This service can be associated with individuals with Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI)

CRT is a service that is based on Medical Necessity (MN) through an assessment conducted by a licensed Psychologist, Occupational Therapist (OT) or Speech and Language Pathologist (SLP).

HCBS STAR+PLUS Waiver Services for qualified members:

- Adaptive aids and medical supplies: include devices, controls, or medically necessary supplies that enable individuals with functional impairments to perform activities of daily living or control the environment in which they live.

- Adult Foster Care (AFC): provides a 24-hour living arrangement in a Health and Human Services (HHSC) contracted foster home for persons who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, minimal help with personal care, help with activities of daily living and provision of or arrangement for transportation. The unit of service is one day. Adult Foster Care Homes must meet the minimum standards described in the STAR+PLUS handbook Section 7100 found at <https://hhs.texas.gov/laws-regulations/handbooks/sph/starplus-handbook>. Adult foster care homes serving four or more participants must be licensed by HHSC under 40 Tex. Admin. Code Chapter 92.
- Assisted living and Residential Care (AL/RC) services: a 24-hour living arrangement in licensed personal care facilities in which personal care, home management, escort, social and recreational activities, twenty-four hour supervision, supervision of, assistance with, and direct administration of medications, and the provision or arrangement of transportation is provided. Under the 1915 (c) waiver, personal care facilities may contract to provide services in three distinct types of living arrangements: assisted living apartments, residential care apartments, or residential care non-apartment settings.
- Emergency Response Services (ERS): are provided through an electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in the community. In an emergency, the individual can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven-day-a-week monitoring capability, helps ensure that the appropriate person or service agency responds to an alarm call from the individual.
- Home delivered meals: Meal services provide hot, nutritious meals served in an individual's home. The benefit limitation is one meal per day, and the need for a home delivered meal must be part of the individual service plan (ISP). Home delivered meals will be provided to individuals who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet individual requirements. Menu plans will be reviewed and approved by a registered dietician licensed by the Texas State Board of Examiners of Dietitians or who has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management. Any agency providing home delivered meals must comply with all state and local health laws and ordinances concerning preparation, handling and serving of food.
- In-home skilled nursing care: includes, but is not limited to, the assessment and evaluation of health problems and the direct delivery of nursing tasks, providing treatments and health care procedures ordered by a physician and/or required by standards of professional practice or state law, delegation of nursing tasks to unlicensed persons according to state rules promulgated by the Texas Board of Nurse Examiners, developing the health care plan, and teaching individuals about proper health maintenance.
- Minor home modifications: services that assess the need for, arrange for, and provide modifications and/or improvements to an individual's residence to enable them to reside in the community and to ensure safety, security, and accessibility.

- Respite care services: temporary relief to persons caring for functionally impaired adults in community settings other than AFC homes or AL/RC facilities. Respite services are provided on an in-home and out-of-home basis and are limited to 30 days per ISP year. Room and board is included in the waiver payment for out-of-home settings.
- Therapy (occupational, physical, speech): includes the evaluation, examination and treatment of physical, functional, speech and hearing disorders or limitations. The full range of activities provided by an occupational or physical therapist, speech or language pathologist, or a licensed occupational or physical therapy assistant under the direction of a licensed occupational or physical therapist, within the scope of his/her state licensure are covered LTSS services.

Transitional Assistance Services (TAS): assists individuals who are nursing facility residents to discharge to the community and set up a household. A maximum of \$2500 is available on a one-time basis to help defray the costs associated with setting up a household. TAS include, but are not limited to, payment of security deposits to lease an apartment, purchase of essential furnishings (table, eating utensils), payment of moving expenses, etc.

*A referral from your PCP is not required ** STAR+PLUS waiver services – for a more inclusive listing of limitations and exclusions, please refer to the current Texas Health and Human Services (HHSC) Provider Manuals located at <https://hhs.texas.gov/services/health/medicaid-chip/provider-information>

Breast Pump Coverage in Medicaid and CHIP

Texas Medicaid and CHIP cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother’s Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant’s Medicaid client number.

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother’s Medicaid ID or the newborn’s Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn’s Medicaid ID.

CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	
STAR Health	STAR Health	STAR Health	
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

*CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

**These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.

Members with Special Needs (STAR, STAR+PLUS, & CHIP)

Overview

Molina uses a program specifically designed to meet the needs of adults and children identified as having special health care needs.

Molina will use Health Risk Coordinators (HRC) familiar with health assessment screening tools and application to work with those new Members who require special needs if identified as meeting Molina's assessment criteria for MSHCN. HRC professionals will coordinate their activities with the Quality Improvement/Utilization Management Department. Members identified with a special health care need will be referred to their PCP. Molina will assign a Case Manager to work with the PCP to establish a plan of care, to assist the PCP with necessary referrals (if needed by the PCP), and to aid the Member

in accessing the services, including any out-of-network referrals, standing referrals, transportation or translation/interpretation services needed.

Non-Emergency Medical Transportation (NEMT) Services (STAR, STAR+PLUS, MMP)

What are NEMT services?

NEMT services provide transportation to covered health care services for Medicaid Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips.

What services are part of NEMT Services?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.
- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is \$25 per day for the member and \$25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a Member needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered health care service is confidential in nature.

If you have a Member you think would benefit from receiving NEMT services, please refer him or her to Molina's Transportation Vendor, Access2Care at (866) 462-4857 (Medicaid)/ (833) 460-4856 (MMP) for more information.

Interpreter/Translation Services (STAR, STAR+PLUS, & CHIP)

All eligible Members who are Limited English Proficient (LEP) will be entitled to receive interpreter services. An LEP individual has a limited ability or inability to read, speak, or write English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations). Molina Members will be entitled to:

- Be provided with effective communications with medical providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Individuals with cognitive difficulties will have ready access to care managers trained to work with cognitively impaired individuals.
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- Be notified by the medical provider that interpreter services are available at no cost to the client.
- Decide, with the medical provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
 - Interpreters must adhere to HHSC policies and procedures regarding confidentiality of client records.
 - Interpreters may, with client written consent, share information from the client's records only with appropriate medical professionals and agencies working on the client's behalf.
 - Interpreters must ensure that this shared information is similarly safeguarded.

In addition, Members are advised in their welcome packet regarding interpretive and translation services and how to access the TTY line for Members who are hard of hearing or speech impaired. Molina's language assistance offers members the opportunity to discuss utilization management issues as well.

Molina/Provider Coordination (STAR, STAR+PLUS, MMP & CHIP)

Members and their families, or authorized representatives including the PCP, are key to the success of a plan of care. Plans of care will be less likely to be followed and result in less than satisfactory outcome without the involvement of the member and when appropriate, the family. Member involvement and family support is important to the completion of necessary treatment.

Molina's care coordination program is designed to identify potential clinical problems, especially those of a chronic or complex nature, engage the Member and PCP in determining a care plan, provide ongoing case management support and care coordination, track and report efforts, adjust staff levels as needed, and monitor the program for outcomes.

Once a plan of care is developed, case managers authorize all needed services, including those to specialists (in or out of network). If the specialist will be delivering care on an on-

going basis, a standing referral will be established. At the Member's discretion and with the specialist's permission, the specialist may be designated as the Member's PCP.

CHIP/CHIP PERINATE NEWBORN

CHIP/CHIP Perinate Newborn Covered Services (this list is not all-inclusive)

Covered CHIP/CHIP Perinate Newborn services must meet the CHIP definition of "Medically Necessary Covered Services," which includes health care services:

- (1) that Molina must arrange to provide to CHIP Members, including all services required by the contract between Molina and HHSC and state and federal law, and all value-added services negotiated by Molina and HHSC; and
- (2) that are
 - a. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;
 - b. provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;
 - c. consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
 - d. consistent with the diagnoses of the conditions;
 - e. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
 - f. are not experimental or investigative; and
 - g. are not primarily for the convenience of the Member or provider.

As provided below, and as determined by HHSC, Molina will also provide coverage for Medically Necessary Behavioral Health Services. **There are no pre-existing condition limits.** There are no spell-of-illness limitations for CHIP and CHIP Perinate members. There is no lifetime maximum on benefits; however, annual, enrollment period or lifetime limitations do apply to certain services, as specified in the following chart.

Please refer to the following websites for the most updated CHIP and CHIP Perinate benefit information:

HHSC Uniform Managed Care Contract Terms and Conditions
<http://www.hhsc.state.tx.us/medicaid/UniformManagedCareContract.pdf>

HHSC – CHIP State Plan <http://www.hhsc.state.tx.us/Medicaid/index.html>.

CHIP/CHIP Perinate Newborn Covered Services

Covered Benefit	CHIP and CHIP Perinate Newborn Members
<p>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</p>	<p>Medically necessary services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care <ul style="list-style-type: none"> • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products not provided free-of-charge to the patient and their administration, • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to TDH-designated Level III Perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section • Hospital, physician and related medical services, such as anesthesia, associated with dental care. • Inpatient services associated with (a) miscarriage or (b) non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> • Dilation and curettage (D&C) procedures; • Appropriate provider-administered medications; • Ultrasounds, and • Histological examination of tissue samples. • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: <ul style="list-style-type: none"> • All stages of reconstruction on the affected breasts; • External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed • Surgery and reconstruction on the other breast to produce symmetrical appearance; and • Treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and Outpatient services and do not count toward the 12-month period limit

Inpatient General Acute and Inpatient Rehabilitation Hospital Services Continued	<ul style="list-style-type: none"> • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> • Cleft lip and/or palate; or • Severe traumatic skeletal and/or congenital craniofacial deviations • Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	<p>Medically necessary services include, but are not limited to, the following services provided in a hospital clinic, a clinic or health center, or an ambulatory health care setting:</p> <ul style="list-style-type: none"> • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine Diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory Services • Radiation and chemotherapy • Blood or blood products not provided free-of-charge to the patient and the administration of these products • Outpatient services associated with (a) miscarriage or (b) non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> • Dilation and curettage (D&C) procedures; • Appropriate provider-administered medications; • Ultrasounds, and • Histological examination of tissue samples. • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. • Surgical implants • Other artificial aids including surgical implants • Outpatient services for a mastectomy and breast reconstruction include: <ul style="list-style-type: none"> • All stages of reconstruction on the affected breasts; • External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed • Surgery and reconstruction on the other breast to produce symmetrical appearance; and

Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Continued

- Treatment of physical complications from the mastectomy and treatment of lymphedemas
- do not count toward the 12-month period limit Implantable devices are covered under Inpatient and Outpatient services and
- Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
 - Cleft lip and/or palate; or
 - Severe traumatic skeletal and/or congenital craniofacial deviations
 - Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.

Physician/Physician Extender Professional Services

- Medically necessary services include, but are not limited to, the following:
- American Academy of Pediatrics recommended well- child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)
 - Physician office visits, inpatient and outpatient services
 - Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation
 - Medications, biologicals and materials administered in physician's office
 - Allergy testing, serum and injections
 - Professional component (in/outpatient) of surgical services, including:
 - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care
 - Administration of anesthesia by physician (other than surgeon) or CRNA
 - Second surgical opinions
 - Same-day surgery performed in a hospital without an over-night stay
 - Invasive diagnostic procedures such as endoscopic examination
 - Hospital-based physician services (including physician-performed technical and interpretative components)
 - Physician and professional services for a mastectomy and breast reconstruction include:
 - All stages of reconstruction on the affected breasts;
 - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
 - Surgery and reconstruction on the other breast to produce symmetrical appearance; and
 - Treatment of physical complications from the mastectomy and treatment of lymphedemas.
 - In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
 - Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to:

Physician/ Physician Extender Professional Services	<ul style="list-style-type: none"> • dilation and curettage (D&C) procedures; • appropriate provider-administered medications; • ultrasounds, and • histological examination of tissue samples. <ul style="list-style-type: none"> • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> • cleft lip and/or palate; or • severe traumatic skeletal and/or congenital craniofacial deviations
Prenatal Care and Pre- Pregnancy Family Services and Supplies	<p>Covered, unlimited prenatal care and medically necessary care related to diseases, illnesses, or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services.</p> <p>Primary and preventative health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.</p>
Birthing Center Services	<p>Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery)</p> <p>Limitations: Applies only to CHIP members</p>
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	<p><u>CHIP Members:</u> Covers prenatal services and birthing services rendered in a licensed birthing center</p> <p><u>CHIP Perinate Newborn Members:</u> Covers services rendered to a newborn immediately following delivery.</p>
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	<p>\$20,000 12-month period limit for DME, prosthetic devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap).</p> <p>Services include DME (equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living, and appropriate to assist in the treatment of a medical condition, including, but not limited to:</p> <ul style="list-style-type: none"> • Orthotic braces and orthotics • Prosthetic devices such as artificial eyes, limbs and braces • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease Hearing aids • Other artificial aids

Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies Continued	<ul style="list-style-type: none"> • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME annual limit <p>Diagnosis-specific disposable medical supplies, including diagnosis specific prescribed specialty formulas and dietary supplements.</p>
Home and Community Health Services	<p>Medically necessary services are provided in the home and community and include, but are not limited to:</p> <ul style="list-style-type: none"> • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies. • Services are not intended to replace the child's caretaker or to provide relief for the caretaker. • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. • Services are not intended to replace 24-hour inpatient or skilled nursing facility services.
Inpatient Mental Health Services	<p>Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to:</p> <ul style="list-style-type: none"> ▪ Neuropsychological and psychological testing When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapter 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. <p>Does not require PCP referral.</p>
Outpatient Mental Health Services	<p>Mental health services, including for serious mental illness, provided on an outpatient basis, but no limited to:</p> <ul style="list-style-type: none"> ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. ▪ Neuropsychological and psychological testing ▪ Medication management ▪ Rehabilitative day treatments ▪ Residential treatment services ▪ Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development) ▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP_CSs shall be providers working through DSHS-contracted Local Mental Health Authority or a separate DSHS-

Outpatient Mental Health Services	<ul style="list-style-type: none"> ▪ contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services. <p>Does not require PCP referral</p>
Inpatient Substance Abuse Treatment Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs <p>Does not require PCP referral</p>
Outpatient Substance Abuse Treatment Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. ▪ Intensive outpatient services ▪ Partial hospitalization ▪ Intensive outpatient services are defined as organized non-residential services providing structured group and individual therapy, educational services and life skills training that consists of at least 10 hours per week for 4 to 12 weeks but less than 24 hours per day. <p>Outpatient treatment is defined as consisting of at least 1 – 2 hours per week of structured group and individual therapy, educational services and life skills training• Does not require PCP referral.</p> <ul style="list-style-type: none"> • Does not require PCP referral.
Rehabilitation Services	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> ▪ Habilitation (the process of supplying a child with the means to reach age appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: <ul style="list-style-type: none"> ○ Physical, occupational and speech therapy ○ Developmental assessment
Hospice Care Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment for unrelated conditions is unaffected • Up to a maximum of 120 days with a 6-month life expectancy • Patients electing hospice services waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime <p>Services apply to the hospice diagnosis</p>

Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	<p>MCO cannot require authorization as a condition for payment for emergency conditions or labor and delivery.</p> <p>Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> ▪ Emergency services based on prudent lay-person definition of emergency health condition ▪ Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers ▪ Medical screening examination ▪ Stabilization services ▪ Access to TDH designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care ▪ for emergency services <p>Emergency ground, air or water transportation</p>
Transplants	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Using up-to-date FDA guidelines, all non- experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.
Vision Benefit	<p>The health plan may reasonably limit the cost of the frames/lenses.</p> <p>Services include:</p> <ul style="list-style-type: none"> • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12- month period
Chiropractic Services	<p>Services do not require physician prescription and are limited to spinal subluxation.</p>
Tobacco Cessation Program	<p>Covered up to \$100 for a 12-month period limit for a health plan approved program. May be subject to formulary requirements</p>
Case Management and Care Coordination Services	<p>These services include outreach informing, case management, care coordination and community referral</p>
Drug Benefits	<p>Services include, but are not limited, to the following:</p> <ul style="list-style-type: none"> • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and <p>Drugs and biologicals provided in an inpatient setting</p>

In addition to covered benefits, Molina offers value added services to its Members. Please refer to the CHIP Value Added Services Addendum on Molinahealthcare.com for more information on value added benefits.

CHIP Covered DME/Supplies

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X		For covered DME items.
Betadine		X	See IV therapy supplies.
Books	X		
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	

Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for treatment of craniofacial anomalies requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times, these items are dispensed in a kit that includes all necessary items for one dressing site
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Ear Molds	X		Custom made, post inner or middle ear surgery.
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.

Enteral Nutrition Supplies	<p style="text-align: center;">X</p>		<p>Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or</p>
Eye Patches	<p style="text-align: center;">X</p>		<p>Covered for patients with amblyopia.</p>
Formula		<p style="text-align: center;">X</p>	<p>Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non- function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include:</p> <ul style="list-style-type: none"> ▪ Identification of a metabolic disorder, dysphasia that results in a medical need for a liquid diet, ▪ presence of a gastrostomy, ▪ or disease resulting in malabsorption that requires a medically necessary nutritional product <p>Does not include formula:</p> <ul style="list-style-type: none"> • For Members who could be sustained on an age- appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. <p>Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are <i>not</i> medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.</p>

Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation

Ostomy Supplies Continued	X		kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Perinatal Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Perinatal nutrition has been
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments;
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catheterization

Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

Limited Home Health Supplies for CHIP

The Vendor Drug Program (VDP) covers Limited Home Health Supplies (LHHS) through the outpatient pharmacy benefit for Medicaid members as of November 12, 2012. **Beginning March 7, 2014, the LHHS formulary will also be applied to CHIP members.**

To provide LHHS to CHIP and Medicaid members enrolled with Molina Healthcare of Texas, pharmacies must be contracted with the VDP and with Caremark, our pharmacy benefit manager (PBM). Enrollment as a Durable Medical Equipment (DME) provider is not required. Providers already enrolled as a Medicaid/CHIP DME provider must submit a claim for LHHS through the pharmacy benefit by way of the pharmacy claim system; these items will not be processed under the medical benefit.

In addition, Molina Healthcare will have certain LHHS products designated as preferred. Molina's preferred diabetic test strips are the TrueTest glucose test strips. Molina Healthcare of Texas has teamed up with the company that makes the True Result monitor, which will be provided to the

LHHS Items

Insulin Syringes (1 cc or less)
Insulin Needles
Blood Glucose Test Strips (for home blood glucose monitor)
Blood Glucose Test Strips with Disposable Monitor
Blood Glucose Monitor (Talking)
Lancets
Spring-Powered Device for Lancet
Aerosol Holding Chamber (for use with metered dose inhaler)
Oral Electrolyte Replacement Fluid
Hypertonic Saline Solution 7%

See www.txvendordrug.com for the full list of LHHS covered products.

Please keep the following in mind when submitting a LHHS claim:

- A Title XIX form is not required for LHHS dispensed through a pharmacy. A prescription (faxed, written, or electronic) is required.

- Claims must be submitted in accordance with the most current NCPDP pharmacy billing standard.

Value Added Services

In addition to covered benefits, Molina offers value added services to its Members. Please refer to Molinahealthcare.com for the most current lists of Value Added Services

CHIP Exclusions from Covered Services (this list is not all inclusive)

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e., cannot be prescribed for family planning)
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Mechanical organ replacement devices including, but not limited to artificial heart
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Acupuncture services, naturopathy and hypnotherapy
- Medications prescribed for weight loss or gain
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)

- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for physical therapy, occupational therapy, and speech therapy school-based services are not covered except when ordered by a physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)

Definitions

CHIP: Children's Health Insurance Program

CHIP Perinatal Eligibility Period: The continuous eligibility period is a 12-month period that begins when the unborn child is enrolled in the CHIP Perinatal Program and continues after the child is born. (Month of enrollment + 11 months.)

CHIP Perinate Program: Means the State of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn Members. Although the CHIP Perinatal Program is part of the CHIP Program, for Contract administration purposes it is identified independently in this Contract. An HMO must specifically contract with HHSC as a CHIP Perinatal HMO in order to participate in this part of the CHIP Program.

CHIP Perinate: A CHIP Perinatal Program member identified prior to birth

CHIP Perinate Member: The Mother of the UNBORN CHIP Perinate Newborn who is eligible to receive Medically Necessary Covered Services related to antepartum care, labor and delivery services and two postpartum visits.

CHIP Perinate Newborn: Means a CHIP Perinate who has been born alive.

CHIP Perinate Unborn Covered Services (this list is not all-inclusive)

Covered Benefit	CHIP Perinatal Unborn (Mother)
Inpatient General Acute and Inpatient Rehab Hospital Services	<p>For CHIP Perinates in families with income at or Below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born); the facility charges are not a covered benefit, however professional services charges associated with labor and delivery are a covered benefit.</p> <p>For CHIP Perinates in families with income the Medicaid eligibility threshold (Perinates who do not qualify for Medicaid once born), benefits are limited to professional services charges and facility charges associated with labor and delivery until birth, and services related to a miscarriage or nonviable pregnancy.</p> <p>Services include but are not limited to the following:</p> <ul style="list-style-type: none"> ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) <p>Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).</p> <p>Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:</p> <ul style="list-style-type: none"> • Dilation and curettage (D&C) procedures • Appropriate provider-administered medications; • Ultrasounds, and • Histological examination of tissue samples.
Skilled Nursing Facilities (Includes Rehab	<p>Not a Covered Service</p>
Outpatient Hospital, Comprehensive Outpatient Rehab Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	<p>Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</p> <ul style="list-style-type: none"> • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biological that are medically necessary prescription and injection drugs

Covered Benefit	CHIP Perinatal Unborn (Mother)
<p>Outpatient Hospital, Comprehensive Outpatient Rehab Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Continued</p>	<ul style="list-style-type: none"> ▪ Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth ▪ Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation ▪ Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis ▪ Laboratory tests are limited to: Non-stress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urine analysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for RH negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. ▪ Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy,
<p>Physician/PE/Professional Services</p>	<p>Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> ▪ Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth ▪ Physician office visits, inpatient and outpatient services ▪ Laboratory, x-rays, imaging and pathology services including technical component and/or professional interpretation ▪ Medically necessary medications, biological and materials administered in Physician's office ▪ Professional component (in/outpatient) of surgical services including: <ul style="list-style-type: none"> ▪ Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth ▪ Administration of anesthesia by Physician (other than surgeon) or invasive diagnostic procedures directly related to the labor with:

Covered Benefit	CHIP Perinatal Unborn (Mother)
Physician/PE/Professional Services Continued	<ul style="list-style-type: none"> • Invasive diagnostic procedures directly related to the labor with delivery of the unborn child • Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) • Hospital-based Physician services (including Physician performed technical and interpretive components) • Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation • Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FUIT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT. • Professional component associated with (a) miscarriage or (b) non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Professional associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> • Dilation and curettage (D&C) procedures • Appropriate provider-administered medications; • Ultrasounds and
Prenatal Care and Pre-Pregnancy Family Service and Supplies	<p>Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include:</p> <ul style="list-style-type: none"> • One (1) visit every four (4) weeks for the first 28 weeks of pregnancy • One (1) visit every two to three (3) weeks from 28 to 36 weeks of pregnancy; and • One (1) visit per week from 36 weeks to delivery <p>More frequent visits are allowed as Medically Necessary. Benefits are limited to:</p> <ul style="list-style-type: none"> • Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. <p>More frequent visits may be necessary for high risk pregnancies. High risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review.</p> <p>Visits after the initial visit must include:</p> <ul style="list-style-type: none"> ▪ Interim history (problems, marital status, fetal status) ▪ Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and

Covered Benefit	CHIP Perinatal Unborn (Mother)
Prenatal Care and Pre-Pregnancy Family Service and Supplies Continued	<ul style="list-style-type: none"> ▪ Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of
Birth Center Services	<p>Covers birthing services provided by a licensed birthing center. Limited to facility services related to labor with delivery.</p> <p>Applies only to CHIP Perinate Members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).</p>
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center	<p>More frequent visits are allowed as Medically Necessary. Benefits are limited to:</p> <ul style="list-style-type: none"> • Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high risk pregnancies. High risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. <p>Visits after the initial visit must include:</p> <ul style="list-style-type: none"> • Interim history (problems, marital status, fetal status) • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client)
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	<p>Not a Covered Benefit, with the exception of a limited set of disposable medical supplies, published at http://www.txvendordrug.com/formulary/limited-hhs.shtml and only when they are obtained from a CHIP-enrolled pharmacy provider.</p>
Home and Community Health Services	<p>Not a Covered Benefit</p>

Covered Benefit	CHIP Perinatal Unborn (Mother)
Inpatient Mental Health Services	Not a Covered Benefit
Outpatient Mental Health Services	Not a Covered Benefit
Inpatient Substance Abuse Treatment	Not a Covered Benefit
Outpatient Substance Abuse Treatment	Not a Covered Benefit
Rehabilitation Services	Not a Covered Benefit
Hospice Care Services	Not a Covered Benefit
ER, including Emergency Hospitals, Physicians and Ambulance Services	<p>HMO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery.</p> <p>Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth</p> <ul style="list-style-type: none"> ▪ Emergency services based on prudent layperson definition of emergency health condition ▪ Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child ▪ Stabilization services related to the labor with delivery of the covered unborn child ▪ Emergency ground, air and water transportation for labor and threatened labor is a covered benefit ▪ Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. <p>Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are</p>
Transplants	Not a Covered Benefit
Vision Benefit	Not a Covered Benefit
Chiropractic Benefit	Not a Covered Benefit
Tobacco Cessation Program	Not a Covered Benefit
Case Management and Care Coordination Services	Covered Benefit
Drug Benefits	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting

CHIP Perinate Exclusions from Covered Services (this list is not all inclusive):

- For CHIP Perinates in families with incomes at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), inpatient facility charges are not a covered benefit for the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) non-viable pregnancy, and postpartum care related to the covered unborn child until birth.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies, with the exception of a limited set of disposable medical supplies, published at <http://www.txvenfordrug.com/formulary/limited-hhs.shtml>, when they are obtained from an authorized pharmacy provider.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the labor with delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to the labor or threatened labor, miscarriage or non-viable pregnancy, and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or post-partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.

- Coverage while traveling outside of the United States and U.S Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa.)
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor with delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or Speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ

Medicare-Medicaid Plan (MMP) Benefit Design

The approach to integrating care for dually eligible individuals eliminates fragmentation in care delivery and financing through contracts with a single managed care organization responsible for delivering all covered Medicare and Medicaid benefits.

Acute Covered Benefits (Medicare)

Dual eligible enrollees will receive acute care, outpatient drug benefits and related services through Medicare. This includes:

- Inpatient and Outpatient Hospital Services (Part A)
- Physician Visits and Other Acute Services (Part B)
- Pharmacy (Part D)

STAR+PLUS Wrap Services (Medicaid)

Molina's STAR+PLUS program will supplement MMP enrollee's Medicare coverage by providing services and supplies that are available under the Texas Medicaid program. These services include:

- Community-based LTSS
- Medicaid Wrap Services
 - There are three categories of Medicaid wrap-around services:
 - Medicaid only services (i.e., services that do not have a corresponding Medicare service);
 - Medicare services that become a Medicaid expense due to meeting a benefit limitation on the Medicare side; and
 - Medicare services that become a Medicaid expense due to coinsurance (cross-over claims).
- Medicare Cost Sharing

Outpatient drug and biologicals, including pharmacy-dispensed and provider-administered outpatient drugs and biologicals not covered by Medicare will be included in Medicaid STAR+PLUS benefits.

Non-Emergency Medical Transportation (NEMT) Services

MMP members are eligible to receive Medicaid-covered NEMT Services. Please see page [XX] for additional information.

Behavioral Health

Medicare provides inpatient and outpatient mental health services for MMP enrollees. STAR+PLUS would provide wrap-around coverage for psychiatry and counseling, and substance use treatment services, including outpatient assessment, detoxification and counseling, and residential services.

Integrated Services

- Service Coordination
- Health Promotion and Wellness
- Disease Management
- Home Health Services
- Coordination of Behavioral Health Services

Medicare-Medicaid Plan (MMP) Flexible Benefits

Flexible Benefits are additional services beyond the services covered by Medicare and Medicaid that promote healthy lifestyles and improve health outcomes among enrollees.

Members and Providers can call Member Services to request an updated and complete list of the Molina MMP Flexible Benefits.

Medicare-Medicaid Plan (MMP) Rewards and Incentives

Molina Dual Options STAR+PLUS MMP members who reside in the community or in a Nursing Facility who have certain health conditions and/or meet other criteria may receive gift cards for getting various tests and health screenings. Some of these tests and screenings include:

- Diabetic members who complete a diabetic eye exam each year;
- Diabetic members who complete an A1c blood test each year;
- Female members age 21-64 who complete a cervical cancer screening test each year;
- Members with cardiovascular disease who complete a cholesterol blood test each year; and
- Female members age 50 to 74 who complete a recommended mammogram each year.

Please note that the above list may not include all the rewards and incentives available to MMP members. The MMP Rewards and Incentives also may change from time to time. Members and Providers can call Member Services to receive a current and complete list of the MMP Rewards and Incentives.

To receive their gift card, a member, or their provider, must call Member Services after completing the necessary test/screening and request the gift card. Gift cards are mailed to members 30-60 days from validation of the service being completed. Members or their provider must initiate the fulfillment process by calling Member Services.

Nominal Gifts (MMP)

Nominal gifts are gifts or promotional items with a monetary value. Providers may not provide promotional items or nominal gifts to a select MCO's current or prospective members or condition promotional items or nominal gifts on enrollment with a MCO.

Chapter 2 - Claims and Billing

Molina follows the billing procedures outlined in the Texas Medicaid Provider Procedures Manual. For full information on Texas Medicaid billing practices and procedures, visit www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

Molina does not have a capitation relationship with providers. As a contracted provider, it is important to understand how the claims process works to avoid delays in the processing of your claims. Provider Services is available to answer any questions about the claims process. The following items are covered in this section for your reference:

- Claims and Encounter Data Guidelines
- Electronic Claim Payment
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Requirements for a Clean Claim
- Timely Filing Process
- Reimbursement Guidance
- Emergency Services Claims
- Corrected Claims
- Billing Members
- Special Billing
- Claims Review and Audit
- Partially Payable Claims
- Overpayments and Incorrect Payment Refund Requests
- Claims Appeals/Reconsiderations
- Fraud and Abuse
- Hospital-Acquired Conditions and Present on Admission Program
- Changes to Claims Guidelines
- Claims Questions

Claims and Encounter Data Guidelines

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 are encouraged to utilize electronic billing through a clearinghouse or Molina's Provider Portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 20554. 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 thirty (30) calendar days from the change.

Paper Claims and Encounter Data Guidelines

Non-electronic claims must be submitted to Molina on a CMS 1500 or UB-04 claim form that is legible and accurate within ninety-five (95) days of the date of service. Molina is also able to accept the UB92. Non-electronic claims that meet the requirements of a clean claim as defined in Title 28 of the Texas Administrative Code Chapter 21 Subchapter T will be paid or denied within thirty (30) days of receipt (18 days for electronic Pharmacy Claims submissions/21 days for non-electronic Pharmacy Claims submissions). Claims that do not meet the clean claim requirements will still be paid or denied in a timely manner where possible, but Molina will not be liable for any late payment penalties on claims that do not meet the requirements of a clean claim.

If electronic claim submission is not possible, please submit paper claims to the following address:

**Molina Healthcare
Attn: Claims
PO Box: 22719
Long Beach, CA 90801**

Please keep the following in mind when submitting paper claims

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

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 per month, and within 30 days from the date of service in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – 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 fifteen (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 (2) types of responses:

- First, Molina will provide a 999 acknowledgement of the transmission
- Second, Molina will provide a 277CA response file for each transaction

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

Electronic Claims Submission Guidelines

Electronic claims must be submitted to Molina using the appropriate Professional and Institutional Encounter guides as shown below, and within 95 days of the date of service.

1. 837 Professional Combined Implementation Guide
2. 837 Institutional Combined implementation Guide
3. 837 Professional Companion Guide
4. 837 Institutional Companion Guide; or
5. National Council for Prescription Drug Programs (NCPDP) Companion Guide

Electronic claims that meet the clean claim requirements as defined in the 28 Tex. Admin. Chapter 21 Subchapters C and T will be paid or denied within thirty (30) days of receipt (excluding Nursing Facilities).

Molina shall pay Network Providers interest at a rate of 1.5% per month (18% per annum) on all clean claims that are not paid within 30 days. Claims that do not meet the requirements of a clean claim will still be paid or denied in a timely manner where possible, but Molina will not be liable for any late-payment penalties on claims that do not meet the requirements of a clean claim.

Molina shall pay or deny Network Pharmacies submitting electronic claims that meet the clean claim requirements as defined in Title 28 Texas Administrative Code Chapter 21 Subchapter T within eighteen (18) days of receipt.

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Provider Portal

- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 20554

Provider Portal:

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

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

Clearinghouse:

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

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

When your Claims are filed via a Clearinghouse:

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

EDI Claims Submission Issues

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

Note: Molina will notify Network Providers in writing of any changes in the list of claims processing or adjudication entities at least thirty (30) days prior to the effective date of change. If Molina is unable to provide at least thirty (30) days notice, the Molina will give Network Providers a 30-day extension on their claims filing deadline to ensure claims are routed to correct processing centers.

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.

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

COB

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina or medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including explanation of benefits (EOBs) and other required documents, by utilizing Molina's Provider Portal. Providers can also submit this information through EDI and Paper submissions.

TPL

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

Coordination of Benefits (COB) and Third-Party Liability (TPL) – MMP

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

Medicaid Coverage for Molina Medicare Members – MMP Only

There are certain benefits that will not be covered by Molina Medicare program, but may be covered by **fee-for-service Medicaid**. In this case, the Provider should bill Medicaid with a copy of the Molina Medicare remittance advice and the associated state agency will process the claim accordingly.

After exhausting all other primary coverage benefits, Provider may submit claims to Molina Medicare. A copy of the remittance advice from the primary payer must accompany the claim or the claim will be denied. If the primary insurance paid more than Molina's contracted allowable rate, the claim is considered paid in full and zero dollars will be applied to the claim.

Requirements for a Clean Claim - Physicians and Non-Institutional Providers

A clean claim relating to physicians or non-institutional providers is comprised of the following (Included are the appropriate CMS references to specific fields):

1. Subscriber's/patient's plan ID number (CMS 1500, field 1a);
2. Patient's name (CMS 1500, field 2);
3. Patient's date of birth and gender (CMS 1500, field 3);
4. Subscriber's name (CMS 1500, field 4) is required, if shown on the patient's ID card;
5. Patient's address (street or P.O. Box, city, state, zip) (CMS 1500, field 5) is required;
6. Patient's relationship to subscriber (CMS 1500, field 6);
7. Subscriber's address (street or P.O. Box, city, state, zip) (CMS 1500, field 7) required but physician or provider may enter "same" if the subscriber's address is the same as the patient's address required by requirement "E;"
8. Subscriber's policy number (CMS 1500, field 11);
9. HMO or insurance company name (CMS 1500, field 11c);
10. Disclosure of any other health benefit plans (11d);
11. Patients or authorized person's signature or notation that the signature is on file with the physician or provider (CMS 1500, field 12);
12. Subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (CMS 1500 field 13);
13. Date of injury (CMS 1500, field 14) is required, if due to an accident;
14. Name of referring physician or other source (CMS 1500, field 17) is required for primary care physicians, specially physicians and hospitals; however, if there is no referral, the physician or provider shall enter "Self-referral" or "None;"
15. I.D. Number of referring physician (CMS 1500 field 17a) is required for primary care physicians, specialty physicians and hospitals; however, if there is no referral, the physician or provider shall enter "Self-referral" or "None;"
16. Narrative description of procedure (CMS 1500, field 19) is required when a physician or provider uses an unlisted or not classified procedure code or an NDC code for drugs;
17. For diagnosis codes or nature of illness or injury (CMS 1500, field 21), up to four diagnosis codes may be entered, but at least one is required (Primary diagnosis must be entered first);

18. Verification number (CMS 1500, field 23), is required if services have been verified. If no verification has been provided, a prior authorization number (CMS 1500, field 23), is required when prior authorization is required and granted;
19. Date(s) of service (CMS 1500, field 24A);
20. Place of service codes (CMS 1500, field 24B);
21. Procedure/modifier code (CMS 1500, field 24 D);
22. Diagnosis code by specific service (CMS 1500, field 24E) is required with the first code linked to the applicable diagnosis code for that service in field 21;
23. Charge for each listed service (CMS 1500, field 24F);
24. Number of days or units (CMS 1500, field 24G);
25. NPI of Rendering physician or provider in box 24j and Billing Provider NPI in box 33a (CMS 1500);
26. Federal tax ID in box 25 (CMS 1500);
27. Whether assignment was accepted (CMS 1500, field 27), is required if assignment under Medicare has been accepted;
28. Total charge (CMS 1500, field 28);
29. Amount paid, (CMS 1500, field 29), is required if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber;
30. Signature of physician or provider or notation that the signature is on file with the HMO or preferred provider carrier (CMS 1500, field 31);
31. Name and address of facility where services rendered (if other than home or office) (CMS 1500, field 32,); and
32. Physician's or provider's billing name, address and telephone number are required, and the provider number (CMS 1500, field 33, 12-90 version) is required if the HMO or preferred provider carrier required provider numbers and gave notice of that requirement to physicians and providers prior to June 17, 2003. For CMS 1500 08-05 version, physician's or provider's **billing** NPI number should be in field 33a.

Per the NUCC (National Uniform Claim Committee) the rendering provider NPI should be submitted in box 24J and the billing provider NPI in box 33A on the paper claim. Below is information regarding the appropriate fields for the rendering and billing provider NPIs. Please work with your billing representative to ensure that NPIs are correctly populated on electronic and paper claims. This will allow Molina to submit accurate claims data to the state agency per state requirements.

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

Required NPI Fields

CMS-1500	Field Location	Required
Referring Provider	Box 17b	Requested*
Rendering Provider	Box 24j	Required

Facility	Box 32a	Requested*
Billing Provider	Box 33a	Required
LTSS Provider Only	Box 33b	Required

Requirements for a Clean Claim - Institutional Providers

Claims must be submitted on UB-04 form.

Required data elements for institutional providers are listed as follows:

1. Provider's name, address and telephone number (UB-04, field 1);
2. Pay to Provider's name, address and telephone number (UB-04, field 2) Optional, use if pay to address is different from address in field 1;
3. Patient control number (UB-04, field 3);
4. Type of bill code (UB-04, field 4) is required and shall include a "7" in the third position if the claim is a corrected claim;
5. Provider's federal tax ID number (UB-04, field 5);
6. Statement period (beginning and ending date of claim period) (UB-04, field 6);
7. Covered days (UB-04, field 7), is required if Medicare is a primary or secondary payor;
8. Patient's name (UB-04, field 8);
9. Patient's address (UB-04, field 9);
10. Patient's date of birth (UB-04, field 10);
11. Patient's gender (UB-04, field 11);
12. Date of admission (UB-04, field 12) is required for admissions, observation stays, and emergency room care;
13. Admission hour (UB-04, field 13) is required for admissions, observation stays, and emergency room care;
14. Type of admission (e.g., emergency, urgent, elective, newborn) (UB-04, field 14);
15. Source of admission code (UB-04, field 15);
16. Discharge hour (UB-04, field 16), required for admissions, outpatient surgeries or observation stays;
17. Patient-status-at-discharge code (UB-04, field 17) is required for admissions, observation stays, and emergency room care;
18. Condition codes (UB-04, fields 18-28), required if appropriate
19. Occurrence codes and all dates (UB-04, fields 31-34), required if appropriate;
20. Occurrence span codes, from and through dates (UB-04, fields 35-36) required if appropriate;
21. Value code and amounts (UB-04, field 39-41) required for inpatient admissions. If no value codes are applicable to the inpatient admission, the provider may enter value code 01;
22. Revenue code (UB-04, field 42);
23. Revenue description (UB-04, field 43);

24. HCPCS/Rates (UB-04, field 44) required if Medicare is a primary or secondary payor;
25. Service date (UB-04, field 45) required if the claim is for outpatient services;
26. Units of service (UB-04, field 46);
27. Total charge (UB-04, field 47) not applicable for electronic billing;
28. Non-Covered charge (UB-04, field 48) required if information is available and applicable;
29. Payor identification (UB-04, field 50);
30. Health Plan identifier number (UB-04, field 51) required;
31. Release of information indicator (UB-04, field 52) required;
32. Prior payments-payor and patient (UB-04, field 54) required if payments have been made to the physician or provider by the patient or another payor or subscriber, on behalf of the patient or subscriber;
33. Billing provider name and identifiers, including NPI (UB-04, field 56) required on all claims;
34. Other Provider ID (UB-04, field 57) Required, Texas providers should include their TPI in this field;
35. Insured's name (UB-04, field 58) is required if shown on the patient's ID card;
36. Patient's relationship to insured (UB-04, field 59);
37. Insured's unique ID number (UB-04, field 60), required, shown on patient's ID card;
38. Insurance Group Name (UB-04, field 61) required if shown on patient's ID card;
39. Insurance group number (UB-04, field 62), required if shown on patient's ID card;
40. Treatment authorization codes (UB-04, field 63) required if services have been authorized;
41. Diagnosis and procedure code qualifier (UB-04, field 66);
42. Principle diagnosis code (UB-04, field 67) Required on all claims;
43. Diagnoses codes other than principal diagnosis code (UB-04, field 67A-Q), are required if there are diagnoses codes other than principal diagnosis;
44. Admitting diagnosis code (UB-04, field 69);
45. Patient's reason for visit (UB-04, field 70), required for unscheduled outpatient visits;
46. Principal procedure code (UB-04, field 74) required if the patient has undergone an inpatient or outpatient surgical procedure;
47. Other procedure codes (UB-04, fields 74A-E) are required as an extension of "46" if additional surgical procedures were performed;
48. Attending physician name and identifiers, including NPI (UB-04, field 76) Required on all claims;
49. Operating Physician's name and identifier, including NPI (UB-04, field 77) Required only when surgical procedure on claim; and
50. Other providers' name and identifiers, including NPI (UB-04, fields 78-79) Requested if information is available.

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

UB-04

Molina began accepting the new UB-04 on March 1, 2007. We are accepting institutional claims filed by facilities such as hospitals, skilled nursing facilities, hospices, and others, using either the UB-92 or UB-04. The new UB-04 claim form may be obtained from the National Uniform Billing Committee web site at www.nubc.org.

Information regarding the revised form may also be found on the CMS website:

<http://www.cms.hhs.gov/MLNMArticles/downloads/MM5072.pdf>.

Molina Required/Requested NPI Fields

UB-04	Field Location	
Billing Provider	Box 56	Required
Attending Provider	Box 76	Requested*
Operating Provider	Box 77	Requested*
Other Provider	Boxes 78 & 79	Requested*

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 95 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 95 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.

Timely Claim Processing (Medicaid)

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within thirty (30) days after receipt of clean electronic claims and forty-five (45) days after receipt of non-electronic clean claims.

The receipt date of a Claim is the date Molina receives notice of the Claim.

Timely Claim Processing (MMP)

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

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

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service as follows:

- Ninety-five percent (95%) of the monthly volume of non-contracted "clean" claims are to be adjudicated within thirty (30) calendar days of receipt.
- Ninety-five percent (95%) of the monthly volume of contracted claims are to be adjudicated within sixty (60) calendar days of receipt.
- Ninety-five percent (95%) of the monthly volume of non-clean non-contracted claims shall be paid or denied within sixty (60) calendar days of receipt.

The receipt date of a Claim is the date Molina receives notice of the Claim.

Reimbursement Guidance and Payment Guidelines

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

Molina utilizes a claims adjudication system that encompasses edits and audits that follow State and Federal requirements 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 and Medicaid Services (CMS), including:
 - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit, the professional organization standard may be used.
 - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.

- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

Emergency Services Claims

If the claim is for emergency service(s), no authorization is required. If Molina has reasonable grounds for suspecting fraud, misrepresentation or unfair billing practices, then additional information from the provider may be requested.

Claims Coding

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 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 submissions.

Modifiers

Modifiers consist of two (2) 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-1-CM/PCS Codes

Molina utilizes International Classification of Disease, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Disease 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny claims that do not meet Molina's ICD-10 Claims 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 “frequency” code. For a complete list of codes, reference the National Uniform Billing Committee’s (NUBC’s) Official UB0-4 Data Specifications Manual.

Revenue Codes

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

Diagnosis Related Group (DRG)

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

Molina processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

NDC

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

Providers will need to submit claims with both HCPCS and NDC codes with the exact NDC that appears on the medication packaging in the 5-4-2 digit format (i.e. xxxxx-xxxx-xx) as

well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding Sources

Definitions

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

Corrected Claims Requirements

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims.

Corrected claims must include the correct coding to denote if the claim is Replacement of Prior

Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P and include the original claim number. **Claims submitted without the correct coding will be returned to the Provider for resubmission.**

EDI (Clearinghouse) Submission:

837P

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
 - "1"-ORIGINAL (initial claim)
 - "7"-REPLACEMENT (replacement of prior claim)

- “8”-VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I

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

Billing Members

- Providers contracted with Molina cannot bill the Member for any covered benefits, beyond applicable copayment, deductibles, or coinsurance. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party
- Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
 - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
 - The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.
 - The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

It is important to note that there are no co-pays for Medicaid managed care members. Medicaid members should not be billed for requesting a copy of their medical record.

Member Acknowledgement Statement

The provider may bill the client only if:

- A specific service or item is provided at the client’s request.
- The provider has obtained and kept a written Client Acknowledgment Statement signed by the client that states:
 - “I understand that, in the opinion of (*provider’s name*), the services or items that I have requested to be provided to me on (*dates of service*) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.”

- “Comprendo que, según la opinión del (*nombre del proveedor*), es posible que Medicaid no cubra los servicios o las provisiones que solicite (*fecha del servicio*) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicite y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud.”

Private Pay Agreement

A provider may bill the following to a Member without obtaining a signed Member

Acknowledgment

Statement:

- Any service that is not a benefit under Molina’s Program (for example, personal care items).
- The provider accepts the Member as a private pay patient. Providers must advise Members that they are accepted as private pay patients at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the Member signs written notification so there is no question how the Member was accepted. Without written, signed documentation that the Medicaid Member has been properly notified of the private pay status, the provider does not seek payment from an eligible Medicaid Member.
- All services incurred on non-covered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the non-covered days. Spell of illness limitations do not apply to medically necessary stays for THSteps client’s birth through 20 years of age. The reduction in payment that is because of the medically needy spend down MNP is limited to children 18 years of age or younger and pregnant women. The client’s potential liability would be equal to the amount of total charges applied to the spend down. Charges to clients for services provided on ineligible days must not exceed the charges applied to spend down.
- The Member is accepted as a private pay patient pending Medicaid eligibility determination and does not become eligible for Medicaid retroactively. The provider is allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactively, the Member notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the Member becomes eligible, the provider must refund any money paid by the Member and file Medicaid claims for all services rendered.
- A provider attempting to bill or recover money from a Member in violation of the above conditions may be subject to exclusion from Molina. In accordance with current federal policy, Members cannot be charged for the Member’s failure to keep an appointment. Only billings for services provided are considered for payment. Members may not be billed for the completion of a claim form, even if it is a provider’s office policy.

Private Pay Form Agreement

A private pay form agreement allows for a reduction in payment by a provider to a Member due to a medically needy spend down (effective September 1, 2003, the MNP is limited to children younger than age 19 years and pregnant women). If a provider accepts a Member as a private pay patient, the Provider must advise the Member that they are accepted as private pay patients at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the Member signs written notification so there is no question how the Member was accepted. Without written, signed documentation that the Medicaid Member has been properly notified of the private pay status, the provider does not seek payment from an eligible Medicaid Member.

There are instances in which the Member is accepted as a private pay patient and a provider may bill a member. This is acceptable, if the provider accepts the patient and informs the member at the time of service that they will be responsible for paying for all services. In this situation, it is recommended that the provider use a Private Pay Form. The provider is allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactively, the Member notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the Member becomes eligible, the provider must refund any money paid by the Member and file Medicaid claims for all services rendered.

SAMPLE

Member Acknowledgment Statement

“I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Molina Healthcare as being reasonable and medically necessary for my care. I understand that HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.”

“Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicaid no cubra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que Molina Healthcare o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el miembro solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud.”

Member Signature

Date

Special Billing

Newborns

The following name conventions are to be used for newborns:

- If the mother's name is "Jane Jones," use "Boy Jane Jones" for a male child and "Girl Jane Jones" for a female child.
- Enter "Boy Jane" or "Girl Jane" in first name field and "Jones" in last name field. Always use "boy" or "girl" first and then the mother's full name. An exact match must be submitted for the claim to process.
- **Do not** use "NBM" for newborn male or "NBF" for newborn female.

Non-Emergency Medical Transportation (NEMT)

Transportation providers should submit claims directly to Access2Care for transportation services provided to Molina members. If there are questions regarding billing requirements for NEMT services, providers should refer to the Provider Manual provided by Access2Care.

Claims Review and Audit

Molina shall use established industry claims adjudications 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 Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in overpayment.

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

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

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 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.

Partially Payable Claims

If Molina believes a claim is only partially payable, the non-disputed sections shall be paid and notification to the physician or provider in writing as to why a disputed section shall not be paid is sent.

If additional information is needed in order to process a claim Molina shall request in writing no later than fifteen (15) days after receipt of claim that the physician or provider attach the information necessary. After receipt of the requested information, Molina shall reply within fifteen (15) days as to whether the claim is then payable.

If Molina audits a submitted claim Molina must pay 100 percent of a claim, within thirty (30) days, subject to the audit. Molina must complete the audit within 180 days after a clean claim is received, and any refund due to Molina shall be made no later than thirty (30) days after the completed audit.

Overpayments and Incorrect Payments Refund Requests

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

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

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

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

Claim Appeals/Reconsiderations

Providers disputing a Claim previously adjudicated must request such action within 120 days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim appeals must be submitted on the Molina Provider Complaints and Appeals Request Form found on Provider website and the Provider Portal. *The form must be filled out completely in order to be processed.* Reconsiderations must be submitted on the Claim Reconsideration/Adjustment Form.

Additionally, the item(s) being resubmitted should be clearly marked as appeal or reconsideration, whichever is applicable, and must include the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the appeal/reconsideration request.
- The Claim number clearly marked on all supporting documents

Forms may be submitted via fax, secure email or mail. Claims Appeals/Reconsideration requested via the appropriate may be sent to the following address:

Molina Healthcare of Texas, Inc.
Attention: Claims Disputes / Adjustments
P.O. Box 165089
Irving, TX 75016

Submitted via fax: (877) 319-6852

Secure email: MolinaTXProviderAppeals/Complaints@MolinaHealthcare.com

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 30 days of receipt of the Claims Dispute/Adjustment request.

Provider Claim Redeterminations – Contracted Providers (MMP Only)

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

- Requests must be fully explained as to the reason for redetermination.
- Previous claim and remittance advice, any other documentation to support the request and a copy of the referral/authorization form (if applicable) must accompany the request.
- Requests for claim redetermination should be sent via email to: MolinaTXProviderAppeals/Complaints@MolinaHealthcare.com.

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

All question pertaining to claim redetermination requests are to be directed to the Member & Provider Contact Center.

Provider Reconsideration of Delegated Claims – Contracted Providers

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

Fraud and Abuse

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

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. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
 - Fractures
 - Dislocations
 - Intracranial Injuries
 - Crushing Injuries
 - Burn
 - Other Injuries
- 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
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
- Surgical Site Infection Following Certain Orthopedic Procedures:
 - Spine
 - Neck
 - Shoulder
 - Elbow
- Surgical Site Infection Following Bariatric Surgery Procedures for Obesity

- Laparoscopic Gastric Restrictive Surgery
- Laparoscopic Gastric Bypass
- Gastroenterostomy
- Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
- Iatrogenic Pneumothorax with Venous Catheterization
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
 - Total Knee Replacement
 - Hip Replacement

What this means to Providers:

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

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information:
<http://www.cms.hhs.gov/HospitalAcqCon>
[d/](#)

Changes to Claims Guidelines

Molina will provide all Network Providers at least ninety (90) days notice prior to implementing a change in claim guidelines, unless the change is required by statute or regulation in a shorter timeframe.

Claims Questions, Re-Consideration and Appeals

Additional details regarding the process and timelines to appeal claim payments can be found in the “Complaints and Appeals” Chapter of this manual.

If a provider has a question or is not satisfied with the information or payment, they have received related to a claim, they should contact Provider Services at (855) 322-4080.

CHIP Cost Sharing Schedule

Enrollment Fees (for 12-month enrollment period)	
At or below 151% of FPL*	\$0
Above 151% up to and including 186% of the FPL	\$35
Above 186% and including 201% of FPL	\$50
Co-Pays (per visit):	
At or below 151% of FPL	Charge
Office Visit (non-preventative)	\$5
Non-Emergency ER	\$5
Generic Drug	\$0
Brand Drug	\$5
Facility Co-pay, Inpatient (per admission)	\$35
Cost-sharing Cap	5% of family's income**
Above 151% up to and including 186% FPL	Charge
Office Visit (non-preventative)	\$20
Non-Emergency ER	\$75
Generic Drug	\$10
Brand Drug	\$35
Facility Co-pay, Inpatient (per admission)	\$75
Cost-sharing Cap	5% of family's income**
Above 186% up to and including 201% of the FPL	Charge
Office Visit (non-preventative)	\$25
Non-Emergency ER	\$75
Generic Drug	\$10
Brand Drug	\$35
Facility Co-pay, Inpatient (per admission)	\$125
Cost-sharing Cap	5% of family's income**

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.

**Per 12-month term of coverage.

No co-payments for Medicaid Members, CHIP Perinate Members and/or CHIP Perinate Newborn Members and CHIP Members who are Native Americans or Alaskan Natives. No co-payments for well-baby and well-child services, preventive services, or pregnancy-related assistance for CHIP Members.

Chapter 3 - Credentialing

The purpose of the Credentialing Program is to assure the Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. 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, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA®). 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, 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 Providers who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Type of Practitioners Credentialed and 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 practitioner
- 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 Practitioners

TAHP CVO

All Medicaid MCOs must utilize the Texas Association of Health Plans' (TAHP's) contracted Credentialing Verification Organization (CVO) as part of its credentialing and recredentialing process regardless of membership in the TAHP. Molina utilizes this process for all lines of business.

The CVO is responsible for receiving complete applications, attestations and primary source verification documents. The MCO must complete the credentialing process for a new Provider and its claim systems must be able to recognize the Provider as a Network Provider no later than ninety (90) Days after receipt of a completed application.

Credentialing Application

The Texas Department of Insurance Standardized Credentialing Application is required for all Practitioners being credentialed and recredentialed with Molina for participation in the network. <http://www.tdi.texas.gov/hmo/crform.html>

If an application does not include required information, Provider is given written notice of all missing information no later than five (5) business days after receipt.

Expedited Credentialing

(TIC 1452 subchapter C) - Practitioners (MD, DO, DPM and therapeutic OD) joining a medical group currently contracted by Molina and meet the following requirements will be eligible for thirty (30) day expedited credentialing:

- Current Texas licensed in good standing with the Texas Medical Board;
- Submits all documentation and other information required as necessary to enable Molina to begin the credentialing process; and,
- Agrees to comply with the terms of Molina's participating Provider contract currently in force with the established medical group.

Expedited Credentialing applies to the following practitioners:

- Physicians
- Podiatrists
- Therapeutic Optometrists
- Dentists
- Dental Specialists
- Licensed Clinical Social Workers
- Licensed Professional Counselors
- Licensed Marriage and Family Therapists
- Psychologists

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 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 fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application** - Provider must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within one-hundred-twenty (120) days. Application must include all required attachments.
- **License, Certification or Registration** - Provider must hold a current and valid license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. 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** - Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members. 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. If a Practitioner does not have a DEA or CDS because it has been revoked, restricted or relinquished due to disciplinary reasons, the Practitioner is not eligible to participate in the Molina network.
- **Specialty** – Provider must only be credentialed in the specialty in which they have adequate education and training. Provider must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education** - Provider must have graduated from an accredited school with a degree in their designated specialty.
- **Residency Training** - Providers must have satisfactorily completed residency programs from accredited training program in the specialty 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 (3) years in length. If the podiatrist has not completed a three (3)-year residency or is not board certified, the podiatrist must have five (5) years of work history practicing podiatry.

- **Fellowship Training** - If the Provider is not board certified in the specialty in which they practice and has not completed a residency program in the specialty 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 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 program from an accredited training 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 (5) 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), Urgent Care or Wound Care. General Practitioners providing only wound care services do not require five (5) 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, it would also be required that the Practitioner providing the supervision and/or oversight be contracted and credentialed with Molina.
- **Work History** - Provider must supply most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) 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 (1) year, the Practitioner must clarify the gap in writing.

- **Malpractice History** - Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance** – Provider must supply 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** – Practitioner 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. Molina will also verify all licenses, certifications and registrations in every State where the Practitioner has practiced. At the time of initial application, the Practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body⁷. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioner 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. Practitioner 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. Practitioner 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.

⁷ 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.

- **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** – Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioner’s activities on Molina's behalf. Practitioners maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **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.
- **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 criminal convictions. Practitioners must not have been convicted of a felony or pled guilty to a felony for a health care related crime including but not limited to health care fraud, patient abuse and the unlawful manufacturing, distribution or dispensing of a controlled substance.
- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioner 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, Practitioner 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** - Practitioner 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 Practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification, sanctions or exclusions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

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 ten (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, Inc. Attention: 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 Practitioners' information, the Credentialing Department will notify the Practitioner

If the Practitioner does not respond within ten (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 appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The 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 a 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 are included in this Provider Manual. Molina will respond to the request within two (2) working days. Molina will share with the Practitioner where the application is in the credentialing process and note any missing information or information not yet verified.

Notification of Credentialing Decisions

A letter is sent to every practitioner with notification of the Professional Review Committee or Medical Director decision regarding their acceptance or non-acceptance, in writing for participation in the Molina network. This notification is sent within ninety (90) calendar days from the receipt of an application for participation by the practitioner as per TAC 28: 11.1402. Copies of the letters are filed in the practitioner's credentials files.

Recredentialing

Molina recredentials every Practitioner at least every thirty-six (36) months.

Excluded Providers

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

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its Member/Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions

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

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusion 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 (for equivalent).
- **Medicare Exclusion Database (MED)** – Molina monitors for Medicare exclusions through the Centers for Medicare and 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 Providers sanctioned with SAM. Molina also monitors the following for all Provider types between the recredentialing cycles.

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

Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a Provider's contract based on quality of care or professional conduct, a certified letter is sent to the Provider describing the adverse action taken and the reason for the action, including notification to the Provider of the right to a fair hearing when required pursuant to Laws or regulations.

Chapter 4 - Member Eligibility

Medicaid (STAR and STAR+PLUS) Eligibility

Medicaid Eligibility Determination

The HHSC is responsible for determining eligibility in the Texas Medicaid program. The following groups are eligible for the STAR and STAR+PLUS programs:

- TANF Adults – Individuals age 21 and over who are eligible for Temporary Aid for Needy Families (TANF). This category may include some pregnant women.
- TANF Children – Individuals under the age of 21 who are eligible for the TANF program. This category may include some pregnant women and some children less than one year of age.
- Pregnant Women – pregnant women who are receiving Medical Assistance Only (MAO). Their family income is below 185% of the Federal Poverty Level (FPL).
- Newborn MAO – children under the age one born to Medicaid eligible mothers.
- Expansion Children (MAO) – Children under age one whose family's income is below 185% FPL.
- Expansion Children (MAO) – Children age 1-5 whose family's income is at or below 133% of FPL.

Verifying Member Medicaid Eligibility

The State of Texas, through HHSC determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The Contractual Agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Medicaid (STAR and STAR+PLUS) Eligibility

Providers are responsible for requesting and verifying current Medicaid eligibility information about the member by asking for the Your Texas Benefits Card and their Molina Healthcare Identification Card (ID card). The Member's Your Texas Benefits Card takes precedence over their Molina Healthcare ID Card.

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's eligibility for the date of service prior to services being rendered. There are two ways to do this:

- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Call Provider Services at the patient's medical or dental plan.

Important: Members can request a new card by calling 1-800-252-8263. Members also can go online to order new cards or print temporary cards at www.YourTexasBenefits.com and see their benefits and case information, view Texas Health Steps Alerts, and more.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients. A copy is required during the appeal process if the client's eligibility becomes an issue.

Your Texas Benefits gives Providers access to Medicaid Health Information

Medicaid providers can log into the site to see a patient's Medicaid eligibility, services and treatments. The portal aggregates data (provided from TMHP) into one central hub – regardless of the plan (FFS or Managed Care). All of this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It's FREE and requires a one-time registration.

To access the portal, visit YourTexasBenefitsCard.com and follow the instructions in the 'Initial Registration Guide for Medicaid Providers.' For more information on how to get registered, download the 'Welcome Packet' on the home page.

YourTexasBenefitsCard.com allows providers to:

- View available health information such as:
 - Vaccinations
 - Prescription Drugs
 - Past Medicaid visits
 - Health Events, including diagnosis and treatment, and
 - Lab Results
- Verify a Medicaid's patient's eligibility and view patient program information.
- View Texas Health Steps Alerts.
- Use the Blue Button to request a Medicaid patient's available health information in a consolidated format.

Patients can also log in to www>YourTexasBenefits.com to see their benefit and case information; print or order a Medicaid ID card; set up Texas Health Steps Alerts; and more.

If you have questions, call 1-855-827-3747 or email ytb-card-support@hpe.com.

Medicaid identification includes:

- State Medicaid Your Texas Benefits Card
- Form 1027-A, Temporary Medicaid Identification Form

Providers can also verify eligibility by:

- Using the Your Texas Benefit Medicaid Card; or on the secure website - YourTexasBenefitsCard.com
- Calling the TMHP Contact Center/Automated Inquiry System (AIS) at 1-800-925-9126
- Visiting TexMedConnect on the TMHP website
- Verifying the Molina Member ID Card
- Calling Molina Member services at (866) 449-6849
- MESAV
- Referencing the monthly PCP Eligibility listing

- Electronic eligibility verification e.g., NCPDP E1 Transaction (for Pharmacies only)
- DFPS (Person) ID (Form 2085-B)
- Provider Portal Providers can log into the Molina Healthcare Provider Self Service Portal (ePortal) at:
<https://eportal.molinahealthcare.com/eportal/providers/login.aspx>. (Use of ePortal requires provider registration.)

Temporary ID Card – Form 1027-A

If a member loses the Your Texas Benefits Medicaid card and needs quick proof of eligibility, HHSC staff can still generate a Temporary Medicaid Eligibility Verification Form (Form 1027- A). Members can apply for the temporary form in person at an HHSC benefits office or call (800) 252-8263 or 2-1-1 (pick a language and then pick option 2). HHSC will provide members with a temporary verification form called Form 1027-A. Members can use this for until they receive their new Your Texas Benefits Medicaid Card.

Overview

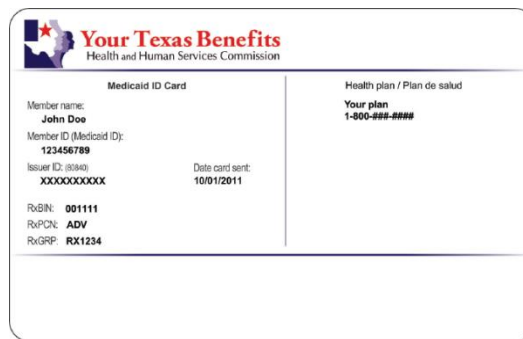
The Texas Health and Human Services Commission is introducing a new system that uses digital technology to streamline the process of verifying a person’s Medicaid eligibility and accessing their Medicaid health history. The two main elements of the system are:

- The Your Texas Benefits Medicaid card, which replaces the Medicaid ID letter (Form 3087) members used to get in the mail every month.
- YourTexasBenefitsCard.com—a secure website where Medicaid providers can get up-to-date information on a patient’s eligibility and history of services and treatments paid by Medicaid.

About the Your Texas Benefits Medicaid Card

The design of the new card conforms to the standards of the Workgroup for Electronic Data Interchange (WEDI). It is designed to show the same type of information shown on private health insurance cards.

<p>The front of the card has:</p> <ul style="list-style-type: none"> ▪ Member name and Medicaid ID number. (i.e. patient control number – PCN). ▪ Managed care program name, if applicable (STAR, STAR Health, STAR+PLUS). ▪ Date the card was issued. ▪ Billing information for pharmacies. ▪ Health plan names and plan phone numbers. ▪ Pharmacy and physician information for members in the Medicaid Limited program. 	<p>The back of the card has:</p> <ul style="list-style-type: none"> ▪ A statewide toll-free number that members can call if they need help or have questions about using the card. ▪ A website (www.YourTexasBenefits.com) where members can get more information about the Medicaid card and access their personal Medicaid health history. The website will be fully functional in a later phase of the project.
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While there are multiple options for providers to access Texas Medicaid member and health information with the new Medicaid ID card, no card reader is required to access the Your Texas Benefits Card provider website.

Option 1: Manual input

The Medicaid ID number (patient control number—PCN) is printed on the front of the card. You can type this number into the provider website, YourTexasBenefitsCard.com, to access your patients' Medicaid eligibility and health information.

Option 2: Basic magnetic stripe card reader

A magnetic card reader can be used to read the Medicaid ID number from the magstripe and automatically enter it into YourTexasBenefitsCard.com.

If you already have a magstripe card reader it will probably work with the card. If not, the Medicaid contractor, HP, is selling a basic USB-based card reader device that can be easily installed and used by providers. Providers also can buy similar card readers online and from other retailers.

Option 3: Integrated point-of-sale (POS) devices

Emdeon, an HP subcontractor, offers a third-party solution for an integrated POS device that can process multiple payers and commercial financial transactions. This commercial solution does not use the Your Texas Benefits card provider portal but will have electronic access to some limited Medicaid eligibility and health information. Pricing from Emdeon varies based on selected services.

If you already own a compatible POS device, you may be able to update the software to read the Medicaid ID number from the card, submit an eligibility verification transaction through their third-party processor, and/or retrieve high-level Medicaid health information. Call the Your Texas Benefits Card help desk at (855) 827-3747 for more information.

Option 4: Electronic transactions

Provider systems can use an electronic data interface (EDI) to request Medicaid eligibility and health data and then represent or store that information within their own systems.

The specifications for the EDI transactions will be published for provider system vendors to use to make updates to their systems. Call the Your Texas Benefits Card help desk at (855) 827-3747 for more information.

Cost to providers for automation options: Access to the provider portal is available at no cost. Any costs for optional hardware or software are the responsibility of the providers. Specific costs will vary based upon the device purchased, the associated services, and the specific seller. Call the Your Texas Benefits Card help desk at (855) 827-3747 for more information about optional automation devices that are available from HP and Emdeon.

Does having a card mean the patient is eligible for Medicaid?

- No. Just because a patient has a Your Texas Benefits Medicaid card, it does not necessarily mean he or she has current Medicaid coverage. You must still verify eligibility.
- Patients are told to keep their Your Texas Benefits Medicaid card even if their Medicaid coverage expires.
- The card can be reused if the patient later regains Medicaid coverage.

What if the member doesn't bring the card to my office?

- You can verify eligibility without a card:
 - On the secure website—YourTexasBenefitsCard.com
 - Through the TMHP Contact Center at (800) 925-9126
 - On TexMedConnect on the TMHP website

Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can get a new card mailed to them by calling (855) 827-3748. Until then, you can verify their eligibility in one of the ways described above.

How am I supposed to use the Your Texas Benefits card?

Use the new Your Texas Benefits Medicaid card to verify a patient's Medicaid eligibility just like you did with the paper Medicaid ID (Form 3087) or verify eligibility through the YourTexasBenefitsCard.com website.

The card's magnetic stripe has the member's Medicaid ID number (PCN) and it can be read by most swipe- style card readers. The Your Texas Benefits Medicaid card is designed to work with standard magnetic card readers that are available at many electronics retailers or online. These readers interface with your computer through a standard USB connection.

The technology company Emdeon is offering Medicaid providers an enhanced point-of-sale device that processes Medicaid eligibility verifications as well as credit card transactions. As with more standard card reading options, Medicaid providers that choose this device are responsible for the cost. For more information, visit www.emdeon.com/pos/. Click on "Contact Us."

What if I don't have a swipe-style card reader?

You don't have to buy a card reader to verify patient eligibility. Medicaid providers can continue to verify eligibility by using a patient's Medicaid ID number (PCN), which will be printed on the card. Then you can:

- Use the secure website— YourTexasBenefitsCard.com
- Call the TMHP Contact Center at (800) 925-9126
- Visit TexMedConnect on the TMHP website

What if I have questions about the card, card reader or the provider website?

Call (855) 827-3747.

What will I be able to do with the new provider website?

The new website lays the foundation for the emerging electronic health network. For now, the YourTexasBenefitsCard.com gives providers another way to verify their patients' Medicaid eligibility.

In the future, providers will be able to use the website to instantly access their Medicaid patients' Medicaid related:

- Claims and encounter data
- Prescription drug history
- Lab results
- Immunization information

The website will give providers a way to capture information showing the time and date their Medicaid patient receives treatment, as well as the type of treatment the patient receives.

You can use as many or as few of the provider website's features as you want. The existing systems for doing business such as checking a patient's Medicaid eligibility and prescribing medication for Medicaid patients will not change.

When will I be able to use the provider website?

- Providers can verify a patient's eligibility using the website now.
- In the coming months, providers will be able to check patient Medicaid health history information.
- Look for updates about the provider website on the HHSC and TMHP websites.

Is e-prescribing available on the provider website?

Not yet—but it will be at a later date. E-prescribing will allow doctors to instantly see if a drug they want to prescribe is covered by Medicaid and what negative interactions the drug is likely to have with other drugs before submitting an electronic prescription to the pharmacy. This will reduce the number of calls from pharmacists proposing alternative drugs and save time for the provider, the pharmacist, and the patient.

CHIP Eligibility

Who is Eligible?

If they do not qualify for Medicaid, Children under age 19 whose family's income is below 200% of the federal poverty level are eligible to enroll in the CHIP program. Members are enrolled with the CHIP program for a continuous 12 months, yet they must re-enroll every 12 months. Eligibility is determined by HHSC's Administrative Services Contractor for the CHIP program.

Verifying CHIP Member Eligibility

It is important for Providers to check the Member's eligibility each time he/she presents to the office for consultation. Molina providers may verify a Member's eligibility by checking the following:

- Molina Member ID Card
- Molina's Provider eportal
- Call Molina Member services at (866) 449-6849
- MESAV
- Monthly PCP Eligibility listing
- Electronic eligibility verification e.g., NCPDP E1 Transaction (for Pharmacies only)
- Calling CHIP Helpline at (877) 543-7669

Molina sends an identification card to each family Member covered under the plan. The Molina Identification Card has the name and phone number of the Member's assigned Primary Care Provider (PCP). A sample of the Molina Identification Card is also included for your reference at the end of this section.

CHIP Perinate Eligibility

Who is Eligible?

A CHIP Perinate (unborn child) who lives in a family with an income at or below Medicaid Eligibility Threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker. A CHIP Perinate will continue to receive coverage through the CHIP program as a "CHIP Perinate Newborn" if he/she is born to a family with an income above the Medicaid Eligibility Threshold and the birth is reported to HHSC's enrollment broker. A CHIP Perinate Newborn is eligible for twelve months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus eleven months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan. Eligibility is determined by a HHSC Administrative Services Contractor.

Molina Dual Options STAR+PLUS MMP Eligibility

Who is Eligible?

Enrollees who wish to enroll in Molina’s Dual Option STAR+PLUS MMP must meet the following eligibility criteria:

- Age 21 or older at the time of enrollment;
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits;
- Required to receive their Medicaid benefits through the STAR+PLUS program as further outlined in the state’s existing Texas Healthcare Transformation and Quality Improvement Program section 1115(a) demonstration. Generally, these are individuals who are age 21 or older who:
 - Have a physical disability or a mental disability and qualify for SSI, or
 - Qualify for Medicaid because they receive Home and Community Based Services (HCBS) STAR+PLUS Waiver Services
- Reside in one of the Demonstration counties

Verifying Eligibility

Verification of enrolleeship and eligibility status is necessary to ensure payment for healthcare services being rendered by the provider to the enrollee. Molina’s Dual Option STAR+PLUS MMP strongly encourages providers to verify eligibility at every visit and especially prior to providing services that require authorization. Possession of a member ID card does not guarantee enrollee eligibility or coverage. It is the responsibility of the practitioner/provider to verify eligibility of the cardholder.

To verify eligibility, providers can use the Provider Portal or call (855) 322-4080.

Continuity of Care (STAR, STAR+PLUS & CHIP)

Molina Members who are involved in an “active course of treatment” have the option to complete that treatment with the practitioner who initiated the care. The lack of a contract with the Provider of a new Member or terminated contracts between Molina and a Provider will not interfere with this option. This option includes the following Members who:

- have pre-existing conditions;
- are in the 24th week of pregnancy (STAR only);
- are receiving care for an acute medical condition;
- are receiving care for an acute episode of a chronic condition;
- are receiving care for a life-threatening illness, or
- are receiving care for a disability

For each Member identified in the categories above, Molina will work with the treating Provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the Member’s needs.

What if a member moves?

If a member moves out of the service area, Molina will continue to cover medically necessary care through the end of the month.

Molina ID Cards

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

Attached are examples for member ID cards for the CHIP/CHIP Perinate Newborn, CHIP Perinate, STAR, STAR+PLUS, STAR+PLUS Dual Eligible members, and MMP Enrollees:

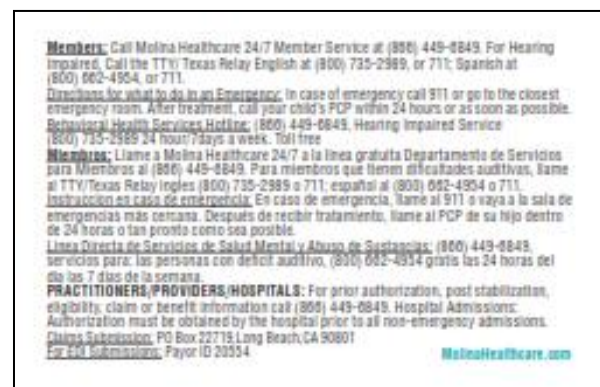
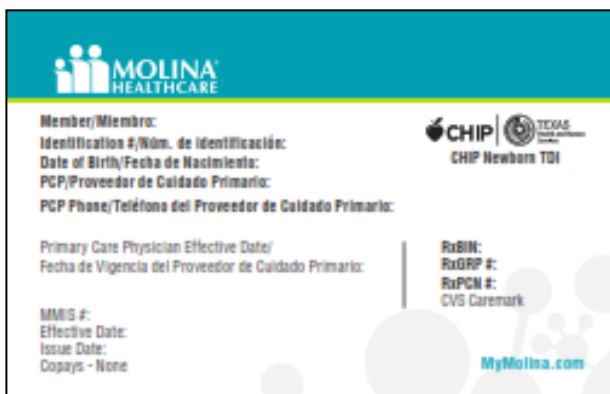
CHIP



KEY TO Molina ID Cards

Molina Healthcare Logo	Program member is enrolled in
Molina Healthcare Member Services Phone Number	Information on who to call in an emergency
Patient Information	Name and address to which you must submit your claims
Behavioral Health Hotline number	Some co-pays/co-insurance and deductibles may apply
PCP information. This area consists of PCP's name, phone number and effective date member was assigned to that PCP	


CHIP PERINATE



KEY TO Molina ID Cards

Molina Healthcare Logo	Date Member is effective with Plan
Program the Member is enrolled in	Molina Healthcare Member Services Phone Number
Patient Information	Information on who to call in an emergency
Delivery Facility Charges based on member's FPL	Practitioners/Providers/Hospitals information for prior authorizations
Delivery Professional Charges based on member's FPL	Name and address to which you must submit your claims

STAR Member ID



Member/Miembro:
Identification #/ Núm. de identificación:
Date of Birth/ Fecha de Nacimiento:
PCP/ Proveedor de Cuidado Primario:
PCP Phone/ Teléfono del Proveedor de Cuidado Primario:

PCP Effective Date/ Fecha de Vigencia del Proveedor de Cuidado Primario:

MMIS #:
 Effective Date:
 Issue Date:

RxBIN:
RxGRP #:
RxPCN #:
 CVS Caremark

MyMolina.com

Members: Call Molina Healthcare 24/7 Member Services at (866) 449-6849. For Hearing Impaired, Call the TTY/ Texas Relay English at (800) 735-2989, or 711; Spanish at (800) 662-4954, or 711. **Directions for what to do in an Emergency:** In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. **Prior Authorization:** Some services require Prior Authorization. Call Member Services if you have questions about which services require Prior Authorization. **Behavioral Health Services Crisis Line:** (800) 818-5837, Hearing Impaired Service (800) 955-8770 24 hour/7 days a week Toll-Free

Miembros: Llamar a Molina Healthcare 24/7 al Departamento de Servicio al cliente al (866) 449-6849. Para personas con problemas auditivos, llamar al TTY/ Texas Relay Inglés (800) 735-2989 o 711; Español al (800) 662-4954 o 711. **Instrucción en caso de emergencia:** En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible. **Autorización Previa:** Algunos servicios requieren autorización previa. Llame a Servicios para miembros si tiene preguntas sobre qué servicios requieren autorización previa. **Línea de Crisis de Servicios de Salud Mental y Abuso de Sustancias:** (800) 818-5837; servicios para las personas con déficit auditivo, (800) 955-8770, gratis las 24 horas del día, los 7 días de la semana.


PRACTITIONERS/PROVIDERS/HOSPITALS: For prior authorization, post stabilization, eligibility, claim or benefit information, call (866) 449-6849. **Hospital Admissions:** Authorization must be obtained by the hospital prior to all non-emergency admissions. **Claims Submission:** PO Box 22719, Long Beach, CA 90801 **For EDI Submissions:** Payor ID 20554

MolinaHealthcare.com

KEY TO Molina ID Cards

Molina Healthcare Logo	Program member is enrolled in
Molina Healthcare Member Services Phone Number	Information on where to call in an emergency
Patient Information	Behavioral Health Hotline number
Name and address to which you must submit your claims	
PCP Information. This area consists of PCP's name, phone number and effective date the member was assigned to that PCP	

STAR+PLUS STAR+PLUS Medicaid Only



Member/Miembro:
Identification #/ Núm. de identificación:
Date of Birth/ Fecha de Nacimiento:
 PCP/ Proveedor de Cuidado Primario:
 PCP Phone/ Teléfono del Proveedor de Cuidado Primario:

PCP Effective Date/ Fecha de Vigencia del Proveedor de Cuidado Primario:

MMIS #:
 Issue Date: <IssueDate_1>

RxBIN: <Bin_number_1>
RxGRP #: <RXGroup_1>
RxPCN #: <RxPCN_1>
 CVS Caremark

MyMolina.com

Members: Call Molina Healthcare 24/7 Member Service at (866) 449-6849. For Hearing Impaired, Call the TTY/ Texas Relay English at (800) 735-2989, or 711; Spanish at (800) 662-4954, or 711. **Directions for what to do in an Emergency:** In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. **Service Coordination:** (866) 409-0039 **Prior Authorization:** Some services require Prior Authorization. Call Member Services if you have questions about which services require Prior Authorization. **Behavioral Health Services Crisis Line:** (800) 818-5837, Hearing Impaired Service (800) 955-8770 24 hour/7 days a week Toll-Free

Miembros: Llamar a Molina Healthcare 24/7 al Departamento de Servicio al cliente al (866) 449-6849. Para personas con problemas auditivos, llamar al TTY/ Texas Relay Inglés (800) 735-2989 o 711; Español al (800) 662-4954 o 711. **Instrucción en caso de emergencia:** En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible. **Coordinación de Servicios:** (866) 409-0039 **Autorización Previa:** Algunos servicios requieren autorización previa. Llame a Servicios para miembros si tiene preguntas sobre qué servicios requieren autorización previa. **Línea de Crisis de Servicios de Salud Mental y Abuso de Sustancias:** (800) 818-5837; servicios para las personas con déficit auditivo, (800) 955-8770, gratis las 24 horas del día, los 7 días de la semana.

PRACTITIONERS/PROVIDERS/HOSPITALS: For prior authorization, post stabilization, eligibility, claim or benefit information call (866) 449-6849. **Hospital Admissions:** Authorization must be obtained by the hospital prior to all non-emergency admissions. **Claims Submission:** PO Box 22719, Long Beach, CA 90801 **For EDI Submissions:** Payor ID 20554

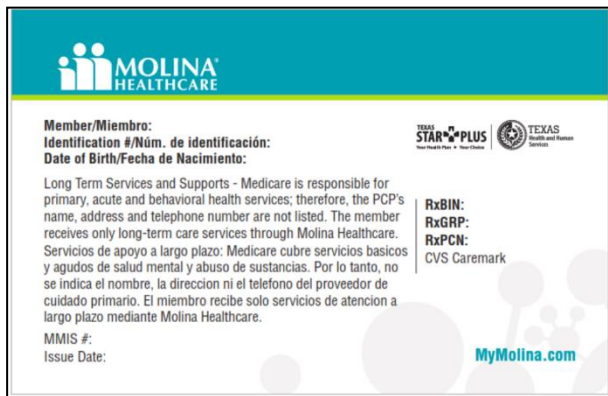
MolinaHealthcare.com

KEY TO Molina ID Cards

Molina Healthcare Logo	Program member is enrolled in
Molina Healthcare Member Services Phone Number	Information on where to call in an emergency
Patient Information	Behavioral Health Hotline number
Name and address to which you must submit your claims	
PCP Information. This area consists of PCP's name, phone number and effective date the member was assigned to that PCP	

STAR+PLUS Dual Eligible (Member also covered by Medicare)

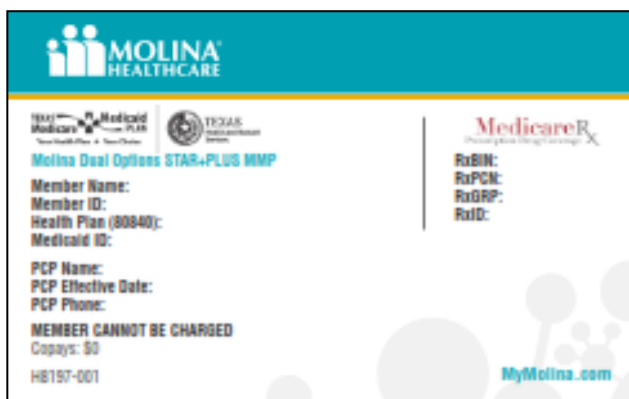
If the member gets Medicare, Medicare is responsible for most primary, acute and behavioral health services; therefore, the PCP's name, address and telephone number are not listed on the Member's ID card. The Member receives long-term services and supports through Molina Healthcare.



KEY TO Molina ID Cards

Molina Healthcare Logo	Program member is enrolled in
Molina Healthcare Member Services Phone Number	Long Term Services and Supports
Patient Information	Behavioral Health Hotline number
Name and address to which you must submit your claims	Information on where to call in an emergency

Dual Options STAR+PLUS MMP (Medicare-Medicaid) ID Cards



KEY TO Molina ID Cards

Molina Healthcare Logo	Program member is enrolled in
Patient Information	Behavioral Health Hotline number
Molina Healthcare Member Services Phone Number	Name and address to which you must submit your claims
PCP Information. This area consists of the PCP's name, phone number and effective date the member was assigned to that PCP.	
Information on who to call in an emergency and information on the 24-hour Nurse Advice Line (for members to get advice on healthcare from a registered nurse	

Provider Panels

Molina distributes provider panels monthly to give information on Members' enrollment with a PCP. The panels are generated and mailed by the first week of each month to all participating providers who practice as PCPs. If a Member arrives at a PCP's office to receive care but does not appear on the current month's panel, the Provider should contact Member Services at (866) 449-6849 to verify eligibility. A sample of the provider panel is included for your reference.

Provider Panels - SAMPLE Molina Healthcare

Fee For Service
Provider Name
Address
City, State Zip

Member	SSN/PIC	Gender	Date of Birth	Enroll Eff.	PCP Eff.	Copay	Member Address
Program: CHIP (Children's Health Insurance Program)							
DUCK, DONALD TX 98000	101010101	M	05/28/1998	04/01/2004	05/01/2004		123 MAIN ST, ANYTOWN,
	PATIENT IDENTIFICATION CODE			ENGLISH			PHONE NUMBER
Program: STAR							
MOUSE, MICKEY ANYTOWN, TX 98000	202020202	M	12/03/1981	02/01/2004	02/01/2004		456 MAINT ST,
	PATIENT IDENTIFICATION CODE			ENGLISH			PHONE NUMBER
Total Number of Members:							2

Chapter 5 - Enrollment, Disenrollment and Member Transfers

Enrollment in Medicaid Programs

No eligible member shall be refused enrollment or re-enrollment, have his/her enrollment terminated, or be discriminated against in any way because his/her health status, pre-existing physical or mental condition, including pregnancy, hospitalization or the need for frequent or high-cost care.

STAR Members

STAR Member Enrollment

A member is free to choose a STAR health plan and PCP. The member will not begin to receive benefits under a Medicaid Managed Care program until the first day of the following month (provided enrollment takes place before the cut-off date for the following month). The cut-off date is generally the 15th of the month.

Example; if enrollment takes place <i>PRIOR</i> to cut-	
Member certified for Texas Medicaid	January 1
Medicaid Benefits Begin	January 1
Member selects health plan and PCP	January 1
Managed care benefits begin	February 1

Example; if enrollment takes place <i>AFTER</i> to cut-	
Member certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Member selects health plan and PCP	January 20
Managed care benefits begin	March 1

Enrollment of Pregnant Women:

Women who are on Medicaid type program 40 may be retroactively enrolled in STAR. Women who are certified for Medicaid type program 40 on or before the 10th of the month will be enrolled in STAR beginning the first of the month of certification. Women who are certified after the 10th of the month will be on fee-for-service Medicaid the month of certification and will be enrolled in STAR beginning the first of the month following the month of certification.

There are two exceptions to this rule:

- Women who are certified at any time in their estimated month of delivery will be enrolled in STAR the first of the following month (prospective enrollment).

- Women who are certified at any time in their actual month of delivery (if known by HHSC before certification) will be enrolled in STAR the first of the following month (prospective enrollment)

Enrollment of Newborns:

Newborns are covered under their mother's Health Plan up to 60 days from the date of birth. Mothers are encouraged to contact Maximus at (800) 964-2777 to enroll the newborn in the STAR program. Mothers can choose to select another health plan for their newborn at the time of enrollment. Mothers are also encouraged to select a PCP for the newborn prior to birth. The PCP assignment can be done by calling Molina Healthcare Member Services at (866) 449-6849.

It is important that providers call the number listed on the Medicaid ID card for plan and provider information (Maximus at (800) 964-2777) or the STAR health plan number listed on the Medicaid ID card.

Health Plan Changes

Member Initiated Change/Span of Eligibility:

Members can change health plans by calling Maximus at (800) 964-2777. However, a member cannot change from one health plan to another health plan during an inpatient hospital stay.

If a member calls to change their health plan on or before the 15th of the month, the change will take place on the first day of the following month. If they call after the 15th of the month, the change will take place the first day of the second month after the request has been made. For example:

- If a request for plan change is made on or before April 15, the change will take place on May 1.
- If a request for plan change is made after April 15, the change will take place on June 1.

Members can change their health plan as often as monthly. If a member chooses to change their health plan, retaliatory action cannot be taken against the member by the Health Plan or provider.

Health Plan Initiated Change (Disenrollment):

Molina has a limited right to request a Member be disenrolled from HMO without the Member's consent. HHSC must approve any HMO request for disenrollment of a Member for cause. HHSC would consider disenrollment under the following circumstances:

- Member misuses or loans Member's Molina membership card to another person to obtain services.
- Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs Molina's or Provider's ability to provide

services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.

- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Molina to treat the underlying medical condition).
- Molina must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation is sent to HHSC, the final decision will be made by HHSC.

Molina must notify the Member of Molina's decision to disenroll the Member if all reasonable measures have failed to remedy the problem. If the Member disagrees with the decision to disenroll the Member from Molina, Molina must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process.

Molina cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

Disenrollment

If a Member makes a request for disenrollment, Molina must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

Automatic Disenrollment/Re-enrollment:

When a member no longer meets the criteria for Managed Care enrollment, the state will automatically disenroll the member. The disenrollment will be effective the first of the following month in which HMO eligibility changes.

Examples for loss of Medicaid managed Care eligibility are:

- The Member has left the service area Molina is contracted to provide HMO coverage in.
- The Member qualifies for HHSC hospice services
- The Member begins Medicare coverage

If a member loses Medicaid eligibility and then regains eligibility within six months, the member is automatically reassigned to their previous health plan and PCP. The member will have the right to request a plan change or PCP change by following the process outlined in the previous pages.

A member's disenrollment request from managed care will require medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment from managed care. HHSC will make final decision.

Note: Providers are prohibited from taking retaliatory action against a member for any reason.

STAR+PLUS Members

STAR+PLUS Member Enrollment

A member is free to choose a STAR+PLUS health plan and PCP. The member will not begin to receive benefits under a Medicaid Managed Care program until the first day of the following month (provided enrollment takes place before the cut-off date for the following month). The cut-off date is generally the 15th of the month.

Example; if enrollment takes place <i>PRIOR</i> to cut-off	
Member certified for Texas Medicaid	January 1
Medicaid Benefits Begin	January 1
Member selects health plan and PCP	January 1
Managed care benefits begin	February 1

Example; if enrollment takes place <i>AFTER</i> cut-off	
Member certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Member selects health plan and PCP	January 20
Managed care benefits begin	March 1

Enrollment of Newborns:

Newborns are covered under their mother's Health Plan up to 60 days from the date of birth if a STAR plan is available in their area. Mothers are encouraged to contact Maximus at (800) 964-2777 to enroll the newborn in the program. Mothers can choose to select another health plan for their newborn at the time of enrollment. Mothers are also encouraged to select a PCP for the newborn prior to birth. The PCP assignment can be done by calling Molina Healthcare Member Services at (866) 449-6849.

It is important that providers call the number listed on the Medicaid Identification Form (Form H3087) for plan and provider information STAR+PLUS Help Line at (800) 964-2777 or the STAR+PLUS health plan number listed on the Medicaid Identification Form (Form H3087).

Health Plan Changes

Member Initiated Change/Span of Eligibility:

Members can change health plans by calling the STAR+PLUS Help Line at (800) 964-2777. However, a member cannot change from one health plan to another health plan during an inpatient hospital stay.

If a member calls to change their health plan on or before the 15th of the month, the change will take place on the first day of the following month. If they call after the 15th of the month, the change will take place the first day of the second month after the request has been made. For example:

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Health Plan Initiated Change (Disenrollment):

Molina has a limited right to request a Member be disenrolled from HMO without the Member's consent. HHSC must approve any HMO request for disenrollment of a Member for cause.

HHSC would consider disenrollment under the following circumstances:

- Member misuses or loans Member's Molina membership card to another person to obtain services.
- Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs Molina's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Molina to treat the underlying medical condition).
- Molina must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation is sent to HHSC, the final decision will be made by HHSC.

Molina must notify the Member of Molina's decision to disenroll the Member if all reasonable measures have failed to remedy the problem. If the Member disagrees with the decision to disenroll the Member from Molina, Molina must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process.

Molina cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

Disenrollment

If a Member makes a request for disenrollment, Molina must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

Automatic Disenrollment/Re-enrollment:

When a member no longer meets the criteria for Managed Care enrollment, the state will automatically disenroll the member. The disenrollment will be effective the first of the following month in which HMO eligibility changes.

Examples for loss of Medicaid managed Care eligibility are:

- The Member has left the service area Molina is contracted to provide HMO coverage in.
- The Member qualifies for HHSC hospice services
- The Member begins Medicare coverage

If a member loses Medicaid eligibility and then regains eligibility within six months, the member is automatically reassigned to their previous health plan and PCP. The member will have the right to request a plan change or PCP change by following the process outlined in the previous pages.

Member's disenrollment request from managed care will require medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment from managed care. HHSC will make the final decision.

Note: Providers are prohibited from taking retaliatory action against a member for any reason.

CHIP Members

Children's Health Insurance Program (CHIP) is a health insurance program for children under the age of 19. CHIP is available to children whose families have low to moderate income but have earned too much money to qualify for Medicaid and do not qualify for private insurance.

CHIP Enrollment

Applying for CHIP:

Families can apply for the CHIP program in one of three ways:

- Complete and mail in a printed application.

- Call (800) 647-6558 and complete the application over the phone.
- Download, complete and mail in an application from <http://www.hhsc.state.tx.us/chip>
- Mail Applications to:

P.O. Box 149276
Austin, TX 78714-9983

Children enrolling in CHIP for the first time, or returning to CHIP after disenrollment, will be subject to a waiting period before coverage actually begins. The waiting period for a child is determined by the date on which he/she is found eligible for CHIP and extends for the duration of three (3) months. If the child is found eligible for CHIP on or before the fifteenth (15th) day of a month, then the waiting period begins on the first day of that same month. If the child is found eligible on or after the 16th day of a month, then the waiting period begins on the first day of the next month.

Please refer to the table below for examples of how the waiting period affects the beginning of coverage. A child will remain covered for a term of twelve (12) continuous months. Families must re-enroll their children every twelve (12) months.

Sample Enrollment Timeline

Action	A	B
Eligibility determination date	January 1-15	January 16-31
1 st day of waiting period	January 1	February 1
Family completes enrollment in CHIP program	Before March CHIP enrollment cut-off (Usually around March 20 th)	Before April CHIP enrollment cut-off (Usually around April 20 th)
First possible date coverage can begin	April 1	May 1

Note: Auto-enrollment of newborns is not permitted. Newborns eligible for Medicaid will not be able to enroll in CHIP.

Enrollment/Disenrollment for Pregnant Members and Infants:

The Administrative Services Contractor will refer pregnant CHIP members, with the exception of Legal Permanent Residents and other legally qualified aliens barred from Medicaid due to federal eligibility restrictions, to Medicaid for eligibility determinations. Those CHIP members who are determined to be Medicaid Eligible will be disenrolled from Molina's CHIP plan. Medicaid coverage will be coordinated to begin after CHIP eligibility ends to avoid gaps in health care coverage.

In the event Molina remains unaware of a member's pregnancy until delivery, the delivery will be covered by CHIP. The Administrative Services contractor will then set the member's eligibility expiration date at the later of (1) the end of the second month following the month of the baby's birth or (2) the Member's original eligibility expiration date. Most newborns born to CHIP Members or CHIP heads of household will be Medicaid eligible. Eligibility of newborns must be determined for CHIP before enrollment can occur. For

newborns determined to be CHIP-eligible, the baby will be covered from the beginning of the month of birth for the period of six (6) months.

Note: Providers are required to notify the Health Plan immediately when a pregnant CHIP or Medicaid member is identified.

Re-enrollment:

Children's Insurance Program will send the Member a notice two (2) months before it is time to renew that child's coverage. To continue enrollment in CHIP the member must reapply for coverage. Members can call the Children's Health Insurance program at (800) 647-6558 for more information on re-enrollment.

Health Plan Changes

Member Initiated:

A Member can ask to change their health plan during the first (initial) three (3) months they are enrolled in Molina Healthcare, during the one open enrollment month every year in their county, or for cause at any time. To request a plan change, the member can call the Children's Health Insurance program at (800) 647-6558.

After the first (initial) three (3) months of enrollment in the health plan or when it is not open enrollment in a Member's county, a Member may, with good reason (for cause), disenroll. The following are examples of reasons members can disenroll:

- The Primary Care Provider (PCP) that has been automatically selected no longer is in the Molina Network of Providers and there are no other doctors in the health plan that will accept that Member's family or that is close to their home.
- The Primary Care Provider (PCP) that the Member picked is no longer in their health plan and he/she was the only doctor in the health plan that spoke the Member's language.
- The Primary Care Provider (PCP) that a family member needs to see because of a special medical need is not a provider for Molina Healthcare.
- The Member no longer lives near any of the Primary Care Providers (PCP) in Molina Healthcare's Provider Network or has moved to a different service delivery area.
- Other - If the Member believes that staying enrolled with Molina Healthcare is harmful and not in their best interest.

Reminder: Members are only allowed to make plan changes once a year. Members may request to change health plans for exceptional reasons or good cause at any time. HHSC will make the final decision.

Health Plan Initiated (Disenrollment):

Molina has a limited right to request a Member be disenrolled from Molina without the Member's consent. HHSC must approve any Molina request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

- Member misuses or loans Member's Molina membership card to another person to obtain services.

- Member is disruptive, unruly, threatening or uncooperative to the extent that the Member's membership seriously impairs Molina's or Provider's ability to provide services to Member or to obtain new Members, and the Member's behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Molina to treat the underlying medical condition).
- Molina must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation is sent to HHSC, the final decision will be made by HHSC.

Molina must notify the Member of Molina's decision to disenroll the Member if all reasonable measures have failed to remedy the problem. If the Member disagrees with the decision to disenroll the Member from Molina, Molina must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process. Molina cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

Molina will not disenroll a child based on a change in the child's health status or because of the amount of Medically Necessary Services that are used to treat the child's condition.

Note: Providers are prohibited from taking retaliatory action against a Member for choosing to disenroll or for any other reason whatsoever.

Disenrollment

Disenrollment may also occur if the Member's child loses CHIP eligibility. A child may lose CHIP eligibility for the following reasons:

- "Aging-out" when CHILD turns nineteen;
- Failure to re-enroll by the end of the 6-month coverage period;
- Failure to pay enrollment fee when due or within the grace period;
- Change in health insurance status, i.e., a CHILD enrolls in an employer-sponsored health plan;
- Death of a CHILD;
- CHILD permanently moves out of the state;
- CHILD is enrolled in Medicaid.
- Failure to drop current insurance if child was determined to be CHIP-eligible because cost sharing under the current health plan totaled 10% or more of the family's gross income.
- Child's parent or Authorized Representative reports a non-qualifying alien status for a non-citizen child, thereby disqualifying the child from CHIP

- Child's parent or Authorized Representative requests (in writing) the voluntary disenrollment of a child.

CHIP Perinate Enrollment and Disenrollment

The CHIP Perinatal coverage provides prenatal care for the unborn children of low-income women who do not qualify for Medicaid. Once born, the child will receive CHIP benefits for the duration of the 12-month coverage period.

Enrollment

The mother of the CHIP Perinate has 15 calendar days from the time the enrollment packet is sent to enroll in a health plan. If a health plan is not selected within 15 calendar days of the member receiving their enrollment packet an automatic assignment will be made. The Perinate mom then has 90 days to select another health plan.

Newborn Process

All CHIP Program and CHIP Perinatal Program Members in a household must be enrolled in the same health plan. Upon certification of CHIP Perinatal Program eligibility, children in the household enrolled in the CHIP Program must be prospectively enrolled in the health plan providing the CHIP Perinatal Program coverage and disenrolled from their current health plan the first possible month. Co-payments, cost-sharing, and enrollment fees still apply to children enrolled in the CHIP Program.

In order to synchronize all CHIP Program and CHIP Perinatal Program Members in a household, all Members will remain with the health plan providing CHIP Perinatal Program coverage until the CHIP Perinate Newborn completes its 12-month eligibility or the end of the traditional CHIP member's enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program Members' information. Once the child's CHIP Perinatal Program coverage expires, the child will be added to his or her siblings' existing CHIP program case. The coverage period for the newly enrolled child will be the remaining period of coverage of the siblings already enrolled in the CHIP Program.

A CHIP Perinate mother in a family with an income at or below Medicaid Eligibility Threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under the Medicaid Eligibility Threshold will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the Doctor at the time of birth and returned to HHSC's enrollment broker.

Health Plan Changes

Member Initiated:

CHIP Perinatal members may request to change health plans under the following circumstances:

- For any reason within 90 days of enrollment in CHIP Perinatal
- If the member moves into a different service delivery area

- For cause at anytime

Reminder: Members are only allowed to make plan changes once a year. Members may request to change health plans for exceptional reasons or good cause. HHSC will make the final decision.

Health Plan Initiated (Disenrollment):

Molina has a limited right to request a Member be disenrolled from Molina without the Member's consent. HHSC must approve any Molina request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

- Member misuses or loans Member's Molina membership card to another person to obtain services.
- Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs Molina's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Molina to treat the underlying medical condition).
- Molina must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation is sent to HHSC, the final decision will be made by HHSC.

Molina must notify the Member of Molina's decision to disenroll the Member if all reasonable measures have failed to remedy the problem. If the Member disagrees with the decision to disenroll the Member from Molina, Molina must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process. Molina cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

Molina will not disenroll a child based on a change in the child's health status or because of the amount of Medically Necessary Services that are used to treat the child's condition.

Note: Providers are prohibited from taking retaliatory action against a Member for choosing to disenroll or for any other reason whatsoever.

Disenrollment:

Disenrollment may also occur if the Member's child loses CHIP Perinate eligibility. A child may lose CHIP eligibility for the following reasons:

- Change in health insurance status, i.e., a CHILD enrolls in an employer-sponsored health plan;
- Death of an unborn child;
- Mother of the unborn child permanently moves out of the state;
- CHILD is enrolled in Medicaid.
- Failure to drop current insurance if child was determined to be CHIP-eligible because cost sharing under the current health plan totaled 10% or more of the family's gross income.
- Child's parent or Authorized Representative reports a non-qualifying alien status for a non-citizen child, thereby disqualifying the child from CHIP
- Child's parent or Authorized Representative requests (in writing) the voluntary disenrollment of a child.

Molina Dual Options STAR+PLUS MMP

All enrollment and disenrollment transactions, including enrollments from one STAR+PLUS MMP to a different MMP, will be processed through the Texas enrollment broker except those transactions related to non-Demonstration plans participating in Medicare Advantage. The State or its enrollment broker provides Medicaid-Medicare Enrollees with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs.

All enrollees of Molina's Dual Option STAR+PLUS MMP are full benefit dual eligible (e.g. they receive both Medicare and Medicaid). Centers for Medicare & Medicaid Services (CMS) rules state that these enrollees may enroll or disenroll from participating plans and transfers between participating plans on a month-to-month basis any time during the year; and will be effective on the first day of the month following the request.

Effective Date of Coverage

The effective date of coverage for enrollees will be the first day of the month following the acceptance of enrollment received through the CMS Transaction Reply Reports file. An enrollment cannot be effective prior to the date the enrollee or their legal representative signed the enrollment form or completed the enrollment election. During the applicable enrollment periods, if Molina's Dual Option STAR+PLUS MMP receives a confirmed enrollment through the CMS TRR file process, Molina's Dual Option STAR+PLUS MMP ensures that the effective date is the first day of the following month.

Disenrollment

Staff of Molina's Dual Option STAR+PLUS MMP may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare MMP enrollee to disenroll except when the enrollee:

- Has a change of residence (includes incarceration – see below) that makes the individual ineligible to remain enrolled in the MMP;
- Loses entitlement to either Medicare Part A or Part B
- Dies
- Materially misrepresents information to the MMP regarding reimbursement for third-party coverage.

When enrollees permanently move out of Molina's service area or leave Molina's service area for over six (6) consecutive months, they must disenroll from Molina's Dual Option STAR+PLUS MMP. There are a number of ways Molina's Enrollment Accounting department may be informed that the enrollee has relocated:

- Out-of-area notification will be received from HHSC and forwarded to CMS on the monthly enrolleeship report;
- Through the CMS DTRR file (confirms that the enrollee has disenrolled)
- The enrollee may call to advise Molina that they have relocated, and Molina will direct them to HHSC for formal notification; and/or
- Other means of notification may be made through the Claims Department, if out-of-area claims are received with a residential address other than the one on file; Molina will inform HHSC, so they can reach out to the enrollee directly to begin the disenrollment process. (Molina's Dual Option STAR+PLUS MMP does not offer a visitor/traveler program to enrollees).

Molina will refer enrollees to HHSC (or their designated enrollment broker) to process disenrollment of enrollees from the health plan only as allowed by CMS regulations. Molina may request that an enrollee be disenrolled under the following circumstances:

- Enrollee requests disenrollment;
- Enrollee enrolls in another plan;
- Enrollee has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan enrollees. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Other reasons for the disenrollment may be one of the following (where Molina will notify HHSC to begin the disenrollment process):

- Enrollee abuses the enrollment card by allowing others to use it to fraudulently obtain services;
 - Enrollee leaves the service area and directly notifies Molina of the permanent change of residence;
 - Enrollee has not permanently moved but has been out of the service area for six (6) months or more;
 - Enrollee loses entitlement to Medicare Part A or Part B benefits;
 - Enrollee loses Medicaid eligibility;
- Molina's Dual Option STAR+PLUS MMP loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina's Dual Option STAR+PLUS MMP will send CMS approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely, before the termination of the plan; and/or
- Molina's Dual Option STAR+PLUS MMP discontinues offering services in a specific service area where the enrollee resides.

In all circumstances, except death, (where HHSC delegates) Molina will provide a written notice to the enrollee with an explanation of the reason for the disenrollment; otherwise HHSC (or its designated enrollment broker) will provide a written notice. All notices will be

in compliance with CMS regulations and will be approved by CMS. Each notice will include the process for filing a grievance.

In the event of death, a verification of disenrollment will be sent to the deceased enrollee's estate. Provider and/or enrollees may contact our Member Services department at (866) 856-8699 to discuss enrollment and disenrollment processes and options.

Inpatient at time of Enrollment

Regardless of what program or health plan the Member is enrolled in at discharge, the program or plan the Member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the Member is no longer confined to an acute care hospital.

Chapter 6 - Healthcare Services (HCS)

Introduction

Healthcare 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, medically necessary review, and restrictions on the use of out-of-network Providers.

Utilization Management (Medicaid, CHIP & MMP)

Molina's UM Department is designed to provide comprehensive health care management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service. Molina works in partnership with Members and Providers to promote a seamless delivery of health care services. The UM team works closely with the Care Management team to ensure Members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. Molina's UM program ensures appropriate and effective utilization of services by:

- Managing benefits effectively and efficiently to ensure appropriate use of health care services.
- Identifying the review criteria, information sources, and processes that are used to review for medical necessity and appropriateness of the requested items and services.
- Coordinating, directing, and monitoring the quality and cost effectiveness of utilization practice patterns of Providers to identify over and under service utilization.
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring that qualified health care professionals perform all components of the UM/CM processes while providing timely responses to Member appeals and grievances.
- Ensuring that UM decision tools are appropriately applied in determining medical necessity decisions.
- Identifying and assessing the need for Care Management through early identification of high or low service utilization, and high cost, chronic diseases;
- Promoting health care in accordance with local, state and national standards;
- Processing authorization requests timely with adherence to all regulatory and accreditation timeliness standards.

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

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

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

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 (Medicaid, CHIP & MMP)

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

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to deny requests (adverse determination);
- Discontinuation of a service;
- Payment for temporarily, out-of-the-area renal dialysis services;
- Payment for emergency services, post-stabilization care or urgently needed services; and
- MMP Only: Payment for any other health service furnished by a Provider that the Member believes is covered under Medicare or if not covered under Medicare, should have been furnished, arranged for or reimbursed by Molina Medicare or the delegated Medical Group/IPA or other delegated entity

Molina follows a hierarchy of medical necessity decision making with Federal and State regulations taking precedence. Molina covers all services and items required by State and Federal regulations.

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

Clinical criteria do not replace State regulations when making decisions regarding appropriate medical treatment for Molina Members.

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

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

Providers can contact Molina's Healthcare Services department at (855) 322-4080 to obtain Molina's UM Criteria.

UM Decisions (MMP Only)

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

1. **Initial Organization Determinations/Pre-service authorization requests** – A request for expedited determinations may be made. A request is expedited if applying the standard determination timeframes could seriously jeopardize the life or health of the Member or the Member's ability to re-gain maximum function. Molina and any delegated Medical Group/IPA or other delegated entity is responsible to appropriately log and respond to requests for expedited initial organization determinations.
 - Expedited Initial requests must be made as soon as medically necessary, within seventy-two (72) hours (including weekends and holidays) following receipt of the validated request; and,
 - Standard requests must be made as soon as medically indicated, within a maximum of fourteen (14) calendar days after receipt of the request.

Delegated Medical Groups/IPAs or other delegated entities are responsible for submitting a monthly log of all Expedited Initial Determinations to Molina's Delegation Oversight Department that lists pertinent information about the expedited determination including Member demographics, data and time of receipt and resolution of the issue, nature of the problem and other information deemed necessary by Molina or the Medical Group/IPA or other delegated entities. The table under number four (4) below describes the CMS required decision timeframes and notification requirements followed by Molina.

2. **Written Notification of Denial** – The Member must be provided with written notice of the determination, if the decision is to deny, in whole or in part, the requested service or payment. If the Member has an authorized representative, the representative must be sent a copy of the denial notice. The appropriate written notice, that has CMS approval, must be issued within established regulatory and certification timelines. The adverse organization determination notice shall be written in a manner that is understandable to the Member and shall provide the following:

- The specific reason for the denial, including the precise criteria used to make the decision that takes into account the Member's presenting medical condition, disabilities and language requirements, if any;
- Information regarding the Member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the Member's behalf;
- Include a description of both the standard and expedited reconsideration process, timeframes and conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;
- Payment denials shall include a description of the standard reconsideration process, timeframes and other elements of the appeal process; and,
- A statement disclosing the Member's right to submit additional evidence in writing or in person.
- Failure to provide the Member with timely notice of an organization determination constitutes an adverse organization determination which may be appealed.

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

Molina or the delegated Medical Group/IPA must coordinate with the SNF, HHA or CORF Provider to ensure timely delivery of the written notice, using the approved NOMNC. All elements of the NOMNC are required and the Member or authorized representative must sign and date the notice to document receipt.

- The NOMNC must include the Member's name, delivery date, date that coverage of services ends and QIO information;
- The NOMNC may be delivered earlier than two (2) days before coverage ends;

- If coverage is expected to be fewer than two (2) days in duration, the NOMNC must be provided at the time of admission; and,
- If home health services are provided for a period of time exceeding two (2) days, the NOMNC must be provided on or before the second to last service date.

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

Upon notification of the Member's request for the fast track, a delivery of the notice is not valid unless appeal, Molina (or the delegated entity) must provide a detailed notice to the Member and to the QIO no later than the close of business, using the approved DENC explaining why services are no longer necessary or covered. The DENC must include the following:

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

Medical Necessity Standards (Medicaid & CHIP Only)

“Medically Necessary” or **“Medical Necessity”** means health services that are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in functions, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life.

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.

Medical Necessity Review (Medicaid, CHIP & MMP)

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 (Medicaid and CHIP Only)

The Molina review process begins with administrative review followed by clinical review if appropriate. The administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage.

- Verifying Member eligibility
- Requested service is a covered benefit.
- Requested service is within the Provider's scope of practice.
- The requested covered service is directed to the most appropriate contracted specialist, facility or vendor.

The clinical review includes medical necessity and level of care

- Requested service is not experimental or investigation in nature.
- Servicing Provider can provide the service in a timely manner.
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition.
- Medical necessity criteria (according to accepted, nationally recognized resources) is met.
- The service is provided at the appropriate level of care in the appropriate facility; e.g., outpatient versus inpatient or at appropriate level of inpatient care.
- Continuity and coordination of care is maintained.
- The PCP is kept apprised of service requests and of the service provided to the Member by other Providers.

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

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

Levels of Administrative and Clinical Review (MMP Only)

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 denial are reviewed by a healthcare 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 (Medicaid, CHIP & MMP)

Molina requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina does not accept clinical summaries; telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations allows such documentation to be acceptable.

Prior Authorizations

For the most current listing of Prior Authorization requirements please go to our website at MolinaHealthcare.com.

The authorization process is comprehensive and, includes the following review processes:

1. Direct Referral
2. Prospective Review
3. Concurrent Authorization
4. Retrospective review

The Utilization Management Department adheres to the HHSC and TDI approved standards for processing referrals, providing authorizations or denial decisions and the notification time frames. These standards are applied to urgent or routine requests for prospective, concurrent and retrospective service. Practitioners/Providers and members may obtain urgent services twenty-four (24) hours a day, seven (7) days a week. Molina Healthcare maintains a toll-free (800) number that is staffed by Telephone Advice Nurses to assist in obtaining services. UM Staff is available eight hours a day during normal business hours for calls regarding UM issues. Staff can receive inbound communication regarding UM issues after normal business hours. Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon. Staff member identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. The toll-free number to reach UM staff for any/all

inquiries or questions regarding the UM process is (866) 449-6849 and you will be prompted to the UM department.

Potential or actual cases of over or underutilization of healthcare services for members will be identified by the Medical Director and the UM staff during all components of UM:

- Prior Authorization (Referrals/Denials to specialty care providers)
- Concurrent Review (Bed-days in comparison to the community standard, length of stay)
- Emergency Room Visits (Frequency of ER use based on community standards)
- Pharmacy Utilization (Outpatient prescription patterns, Brand fill rate)
- Member Satisfaction Survey (Referral process, Obtaining needed care)
- Re-admissions to an acute care facility based on same or similar diagnosis within 30 days following discharge.

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at www.MolinaHealthcare.com.

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

- Member demographic information (Name, DOB, ID #, etc.).
- Provider demographic information (Referring provider and referred to Provider/facility).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure (including all appropriate CPT and HCPCS Codes).
- Location where the 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.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Payment is contingent upon medical necessity and member eligibility at the time of service.

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the member's clinical situation. The definition of expedited/urgent is when

the situation where the standard time frame or decision-making process could seriously jeopardize the life or health of the enrollee or could jeopardize the enrollee's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited requests for authorization, a determination is made as promptly as the member's health requires and no later than seventy-two (72) hours after we receive the initial request for service in the event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a member's life or health. For a standard authorization request, Molina makes the determination and provides notification within three (3) calendar days for CHIP and three (3) business days for Medicaid.

Providers who request prior authorization 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 (855) 322-4080.

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 the method of authorization request receipt.

For MMP Providers

Molina abides by CMS rules and regulations for all organization determinations/pre-service authorization requests and will allow a peer-to-peer conversation in limited circumstances.

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

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

If you wish to dispute Molina's adverse Organization Determination (denial) we may only process the request by following the Standard or Expedited appeal process. This means that if you contact Molina to request a Peer-to-Peer review, we will advise you that you must follow the rules for requesting a Medicare appeal. Refer to the Complaints, Grievance and Appeals of this Provider Manual.

Requesting Prior Authorization

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

- **Provider Portal:** Participating Providers are encouraged to use the Molina Web Portal for prior authorization submission. Instructions for how to submit a Prior Authorization Request are available on the Portal. The benefits of submitting your prior authorization request through the Provider portal are:
 - Create and submit Prior Authorization Requests.
 - Check status of Authorization Requests.
 - Receive notification of change in status of Authorization Requests.
 - Attach medical documentation required for timely medical review and decision making.

The Service Request / Authorization page has 4 functionalities:

- Service Request / Authorization Status Inquiry
- Create Service Request / Authorization
- Open an Incomplete Service Request / Authorization
- Create Service Request / Authorization Templates

One of the following may be used when searching for Service Request/ Authorization:

- Molina Healthcare Member Number
- Member Name
- Service Request Number
- Refer to Provider
- Refer from Provider/Facility

The following shows the information required to submit a Service Request/ Authorization:

- Patient Information (this information will auto populate with a successful member search)
- Service Information
- Provider Information
- Referring Provider Information
- Referred to Provider Information
- Additional Provider Access
- Rendering Facility Information
- Supporting Information

- **Fax:** The Prior Authorization form can be faxed to Molina at:

Authorization Type	Fax Number
Prior Authorizations <ul style="list-style-type: none">• Medicaid/CHIP• Nursing Facilities (Medicaid/CHIP/MMP)• MMP• LTSS	(866) 420-3639 (844) 420-3639 (844) 251-1450 (844) 304-7127
Radiology Authorizations	(877) 731-7218
NICU Authorizations	(877) 731-7218

Pharmacy Authorizations <ul style="list-style-type: none"> • Medicaid/CHIP • MMP • MMP J Code Requests 	(888) 487-9251 (866) 290-1309 (844) 251-1451
Behavioral Health Authorizations	(866) 617-4967
Transplant Authorizations	(877) 731-7218

- **Phone:** Prior Authorizations can be initiated by contacting Molina’s UM Department at **(855) 322-4080**. It may be necessary to submit additional documentation before the authorization can be processed.
- **Mail:** Prior Authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:

Molina Healthcare of Texas
Attn: Healthcare Services Dept.
5605 N. MacArthur Blvd., Suite 400
Irving, TX 75038

PA Not Required

Returned PA Requests forms marked with “PA Not Required” indicate that prior authorization is not required for that services. However, this does not mean that service is approved. This is confirmation of medical necessity only. The authorization is subject to the benefit plan limitations, exclusions and conditions, as well as the member’s eligibility on the date that services are rendered. This is not an approval for claim payment. Claims will be reviewed for correct coding and edits may be applied.

Authorization Turn-Around Times

TYPE OF REQUEST	HHSC – STAR, STAR+PLUS	CHIP	MMP
Non-urgent pre-service decisions	Within 3 business days after receipt of request	Within 3 calendar days written notice from date and time of receipt (should meet the immediacy of the need, not to exceed three).For determinations concerning an acquired brain injury, in addition to the information outlined above, notification of the determination through a direct telephone contact to the individual making the request is also required.	Within 3 business days after receipt of request
Urgent pre-service	Within 72 clock hours of receipt of request	Within 72 clock hours of receipt of the request	Within 1 business day of receipt of request

<p>Post-stabilization care subsequent to emergency room treatment</p>	<p>Will provide the notice to the treating physician or other health care provider within the time appropriate to the circumstances not later than one hour after the time of the request; when denying post-stabilization care requests or life-threatening conditions requests by a treating physician or other health care provider.</p>	<p>Within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, MHT shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request, unless the request is received outside of the period requiring the availability of appropriate personnel, the determination must be issued and transmitted within one hour from the beginning of the next time period requiring appropriate personnel. Followed by a letter within three working days notifying the patient, the patient's representative and the provider of record.</p>	<p>Will provide the notice to the treating physician or other healthcare provider within the time appropriate to the circumstances, not later than one hour after the time of the request for life threatening/post-stabilization.</p>
<p>Urgent concurrent review (i.e. inpatient, ongoing ambulatory services)</p>	<p>Within 24 clock hours of receipt of request.</p>	<p>Within 24 hrs. of receipt to provider/requestor by phone or electronic transmission to provider, unless the request is received outside of the period requiring the availability of appropriate personnel, then within 24 hours of the beginning of the next business day by phone or electronic transmission to provider. Followed by a letter within three working days notifying the patient, or person acting on behalf of the patient and the provider of record of the adverse determination.</p>	<p>Within the NCQA Standard of 24 Clock hours of the receipt of the request</p>

Post-service decisions	30 calendar days (for par providers notification timelines should be reviewed prior to processing post service decisions unless EMTALA applies)	30 calendar days (For Par providers, notification timelines should be reviewed prior to processing post service decisions unless EMTALA applies)	30 calendar days (For Par providers, notification timelines should be reviewed prior to processing post service decisions unless EMTALA applies)
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Definitions:

Pre-Service – A request that must be approved in part or whole in advance of the member obtaining medical care or services. Pre-authorizations and Pre-certifications are pre-service decisions.

Post-Service – Any request for coverage of care of service that a member has already received.

Concurrent – Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care.

Urgent – Any request for medical care of treatment which could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, based on a prudent layperson’s judgment, or in the opinion of the practitioner would subject the member to severe pain that cannot be managed adequately without the care or treatment that is subject of the request.

Non-Urgent – This request will not involve any unnecessary interruption in the member’s treatment for decision-making that may jeopardize the member’s life, health, or ability to recover.

Emergency Services (Medicaid and CHIP Only)

Emergency Services means: health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

- Place the individual's health in serious jeopardy;

- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part;
- Result in serious disfigurement; or,
- For a pregnant woman, result in serious jeopardy to the health of the fetus.

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

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

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

Molina accomplishes this service by providing a twenty-four (24) hour Nurse Advise Line for post business hours. In addition, the 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: Molina contracts with vendors that provide twenty-four (24) hour Emergency Services for ambulance and hospitals. 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 and the Member will be responsible for payment.

Members over-utilizing the emergency department will be contacted by Molina Case Managers whenever possible to determine the reason for using Emergency Services.

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

Emergency Services (MMP Only)

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

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

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

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

Emergency Services and Post-Stabilization Services (MMP Only)

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

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

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

For Members within our service area: Molina contracts with vendors that provide twenty-four (24) hour Emergency Services for ambulance and hospitals.

Molina and its contracted Providers must provide emergency services and post-emergency stabilization and maintenance services to treat any Member with an Emergency Medical Condition in compliance with Federal Law. An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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

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

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

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

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 twenty-four (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 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 (Medicaid & CHIP Only)

If a Member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility are not covered services.

Prospective/Pre-Service Review (MMP Only)

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

- a. Member eligibility;
- b. Member covered benefits;
- c. The service is not experimental or investigational in nature;
- d. The service meets medical necessity criteria (according to accepted, nationally recognized resources);
- e. All covered services, e.g., test, procedure, are within the Provider's scope of practice;
- f. The requested Provider can provide the service in a timely manner;
- g. The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition;
- h. The requested covered service is directed to the most appropriate contracted specialist, facility or vendor;
- i. The service is provided at the appropriate level of care in the appropriate facility; e.g. outpatient versus inpatient or at appropriate level of inpatient care;
- j. Continuity and coordination of care is maintained; and

- k. The PCP is kept apprised of service requests and of the service provided to the Member by other Providers.

Inpatient/Concurrent Review (Medicaid & CHIP)

Molina performs concurrent inpatient review to ensure patient safety, medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated 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 twenty-four (24) hours of the request. Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an inpatient, when the clinical record supports the medical necessity for the need for 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 the observation level of care has failed. Upon discharge the Provider must provide Molina with a copy of the Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient/Concurrent Review (MMP Only)

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

The inpatient review process assures the following:

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

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

Inpatient Status Determinations

Molina's UM staff follow CMS guidelines to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all

coverage, coding and medical necessity requirements (refer to the Medical Necessity Standards section of this manual).

Inpatient Facility Admission (MMP Only)

Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. Proper notification is required by Molina on the day of admission to ensure timely and accurate payment of hospital claims. Delegated Medical Groups/IPAs must have a clearly defined process that requires the hospital to notify Molina on a daily basis of all hospital admissions.

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

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

UM staff 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 for participating hospitals when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates. If it is determined that the subsequent admission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

- A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
 - Premature or inadequate discharge from the same hospital;
 - Issues with transition or coordination of care from the initial admission;
 - For an acute medical complication plausibly related to care that occurred during the initial admission.

- Readmissions that are excluded from consideration as preventable readmissions include:
 - Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
 - 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.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within twenty-four (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.

Exceptions (Medicaid & CHIP)

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

Post Service Review

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Molina Member or there was a Molina error, a Medical Necessity review will be performed. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, 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 affirms that all UM decision making is based solely on appropriateness of care and service and existence of coverage for its Members, and not on the cost of the service to either Molina or the delegated group. Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care.

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 (855) 322-4080 during normal business hours, Monday through Friday (except for Holidays) from 8:00 a.m. to 5:00 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 Provider Portal for UM access.

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

For MMP Providers: "Emergency Services" means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-stabilization Care Services.

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.

Notification of Denied Services

Molina will notify the Member, the Member's Authorized Representative, or the Member's Provider of Record of the Determination. Molina must issue a determination (approval or denial) within regulatory timeframes. The requesting provider will be notified via fax of the offer for a Peer to Peer review and provided information on how to reach the Molina Healthcare Medical Director for the Peer to Peer review prior to a denial being issued. If, after the treating and/or attending physician discusses the case with the CMO/Medical Director, and the decision for a denial is made, an adverse determination letter is generated and mailed to the member, physician and facility within 24 hours of the determination.

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, self-referral, provider referral, etc. It is the responsibility of contracted Providers to assess Members and with the participation of the Member and/or their authorized representative(s), create an individualized care plan (ICP). The ICP is documented in the medical record and is updated as conditions, need and/or health status change. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

Molina staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

There are two (2) main coordination of care processes for Molina Members. The first occurs when a new Member enrolls in Molina and needs to transition current medical care to Molina contracted Providers. Mechanisms within the enrollment process identify the Members and the Member Services reach out to Members to assist in obtaining authorizations, transferring to contracted DME vendors, receiving approval for prescription medications, etc. The second coordination of care process occurs when a Molina Member's benefits will be ending, and they need assistance in transitioning to other care.

The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

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

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

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 members may select or change their PCP by contacting Member Services

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Referrals from a Molina PCP are not required for a Member to receive specialty services; however, prior authorization may be required. Members are allowed to directly access women health specialists for routine and preventive health.

Continuity of Care and Transition of Members

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

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

For additional information regarding continuity of care and transition of Members, please contact Molina at (855) 322-4080.

What if a member moves?

If a member moves out of the service area, Molina will continue to cover medically necessary care through the end of the month.

Clinical Trials (MMP Only)

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

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

NOTICE Act (MMP Only)

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

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 him or herself, or unable to protect him or herself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under 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

Texas Health and Human Services Office of Inspector General
Phone: 1-800-436-6184
Website: www.oig.hhsc.texas.gov

Adult Abuse

Texas Health and Human Services Office of Inspector General
Phone: 1-800-436-6184
Website: www.oig.hhsc.texas.gov

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

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

Continuity and Coordination of Provider Communication

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

Care Management (Medicaid & CHIP)

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

PCP Responsibilities in Care Management Referrals (Medicaid & CHIP)

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

Case Manager Responsibilities (Medicaid & CHIP)

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:

- Monitors and communicates the progress of the implemented plan of care to all involved resources.
- Serves as a coordinator and resource to team Members throughout the implementation of the plan and makes revisions to the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self help.

- Monitors progress toward the Member's achievement of treatment plan goals in order to determine an appropriate time for the Member's discharge from the CM program.

Health Management (Medicaid & CHIP)

The tools and services described here are educational support for Molina Members. We may change them at any time as necessary to meet the needs of Molina Members.

Health Education/Disease Management (Medicaid & CHIP)

The Disease Management Program is a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for chronic medical conditions. Disease management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall health.

Molina systematically identifies members who qualify for its DM programs, but also accepts provider referrals and member self-referrals. Systematic identification means use of a rules-based, consistent, population-based process to identify all eligible members according to the eligibility criteria defined for the program. Eligibility for DM programs may be based on the intensity of the disease or special characteristics of the population.

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

For more info about our programs, please call: Provider Services Department at (855) 322-4080 (TTY/TDD at 711 Relay). Visit www.MolinaHealthcare.com

Member Newsletters (Medicaid & CHIP)

Member Newsletters are posted on the www.MolinaHealthcare.com website at least (two) 2 times a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials (Medicaid & CHIP)

Members are able to access our easy-to-read materials are about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, Members are directed to ask their doctor or visit our website.

Program Eligibility Criteria and Referral Source (Medicaid & CHIP)

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 newsletters, 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.

Multiple sources are used to identify the total eligible population. These may include the following:

- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim with a relevant CMS accepted diagnosis or procedure code;
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members;
- 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 (Medicaid & CHIP)

Contracted Providers are notified as appropriate, when their patients are enrolled in a health management program. Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Patient education resources;
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines; and
- Preventive Health Guidelines;

Additional information on health management programs is available from your local Molina HCS Department toll free at (855) 322-4080.

Case Management (Medicaid & CHIP)

Molina provides a comprehensive ICM program to all Members who meet the criteria for services. The ICM 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 case managers may be licensed professionals and are educated, trained and experienced in the Care Management process. 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 approval from the Member's PCP. The Molina case manager will arrange individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina case manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Case Management: Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the ICM 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 Case 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 (877) 665-4622.

Care Management (MMP)

The Integrated Care Management Program provides care coordination and health education for disease management, as well as identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals. Care Management focuses on the delivery of quality, cost-effective, and appropriate healthcare services for Members who have been identified for Molina's ICM program. Members may receive health risk assessments that help identify physical health, behavioral health and medication management problems to target high-needs members who would benefit from assistance and education from a case manager.

Additionally, functional, social support and health literacy deficits are assessed, as well as safety concerns and caregiver needs. To initiate the care management process, the Member is screened for appropriateness for ICM program enrollment using specified criteria. Criteria are used for opening and closing cases appropriately with notification to Member and Provider.

1. **The role of the Case Manager includes:**

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

2. **Referral to Care Management may be made by any of the following entities:**

- Member or Member's designated representative(s);
- Member's primary care Provider;
- Specialists;
- Hospital Staff;
- Home Health Staff; and
- Molina staff.

Complex Case Management (CCM)

The CCM Program is designed to be a systematic approach to monitoring known or potentially complex and high cost medical cases. The program is based on a member advocacy philosophy designed and administered to assure the member value-added coordination of healthcare and services; to increase continuity and efficiency; and produce optimal outcomes. The focus and responsibility of the program integrates all phases of care for members with complex needs and/or members who require services that are "carved out" from coverage based on contractual arrangements, to ensure continuity and prevent disruption of needed medical care.

CCM is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitates communication between the member's Primary Care Physician, the member, family members, other practitioners, facility personnel, ancillary providers and community resources as applicable.

Practitioners may also contact Molina's Provider Services during business hours Monday-Friday toll free (855) 322-4080 for questions regarding the referral process to complex case management.

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women (CPW) provides services to children with a health condition/health risk, birth through 20 years of age and to high-risk pregnant women of all ages, in order to encourage the use of cost-effective health and health-related care. Together, the case manager and family shall assess the medical, social, educational and other medically necessary service needs of the eligible recipient. The disclosure of medical records between Providers, Molina Healthcare and CPW does not require a medical release form from the member.

To request case management services, please call the Texas Health Steps Outreach and Informing Hotline at (877) 847-8377. Providers may also visit the Texas Department of State Health Services website for additional information. (<http://www.dshs.state.tx.us/caseman/default.shtm>)

Coordination of Covered Services Not Directly Provided by the Molina Network (Medicaid, & CHIP)

The ***Texas Medicaid Provider Procedures Manual (TMPPM)*** is the providers' principal source of information about Texas Medicaid. The manual is regularly updated to reflect the most recent policy and procedure changes. Updates are generally available the month following the effective date of the change. For advanced notification of upcoming changes, providers should monitor banner messages, which appear at the beginning of their Remittance and Status (R&S) Reports, and the corresponding website articles published on TMHP's website.

Molina will assist providers in making necessary arrangements to provide home and community support services to integrate covered services not directly provided by the Molina network, including:

Coordination with Non-Medicaid Managed Care Covered Services for STAR, STAR+PLUS and MMP

Molina will make our best effort to implement a systematic process to enlist the involvement of community organizations that may not be providing STAR+PLUS, STAR or MMP-covered services but are otherwise important to the health and wellbeing of Members. Molina will also make our best effort to establish relationships with these community organizations in order to make referrals for CSHCN and other members who need community services. These organizations may include, but are not limited to:

- Early Childhood Intervention (ECI) Case Management / Service Coordination
- Early Childhood Intervention Specialized Skills Training
- Texas Health Steps Dental (including orthodontia)
- Texas Health Steps Environmental Lead Investigation (ELI)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program

- Admissions to inpatient mental health facilities as a condition of probation
- Department of State Health Services (DSHS) Targeted Case Management (non-capitated service coordinated by LMHAs until August 31, 2014)
- DSHS Mental Health Rehabilitation (non-capitated until August 31, 2014)
- Case management for children and pregnant women
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitation Services Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Health and Human Services Commission (HHSC) hospice services
- STAR - Texas Health Steps Personal Care Services for Members birth through age 20
- STAR+PLUS – Nursing Facility Services (non-capitated until February 28, 2015)
- STAR+PLUS, PASRR screenings, evaluations, and specialized services
- HHSC contracted providers of long-term services and supports (LTSS) for individuals who have intellectual or developmental disabilities.
- HHSC contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities.

Additional coordination of services will be provided for: Dental services, Texas agency administered programs and case management services as well as Vendor Drugs (out-of-office drugs).

Coordination with Non-CHIP Covered Services

Molina will also make its best effort to coordinate Non-CHIP covered services with various community organizations in order to make referrals for members who need community services. We will assist our CHIP Program and/or CHIP Perinatal Program Members with accessing programs such as Texas agency administered programs, case management services, and essential public health services.

Molina Special Needs Plan Model of Care (MMP Only)

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

1. **Targeted Population** – Molina operates Medicare Dual Eligible Special Needs Plans (SNP) for Members who are fully eligible for both Medicare and Medicaid. In accordance with CMS regulations, Molina has a SNP Model of Care that outlines Molina's efforts to meet the needs of the dual eligible SNP members. This population has a higher burden of multiple chronic illnesses and sub-populations of frail/disabled Members than other Medicare Managed Care Plan types. The Molina Dual Eligible Special Needs Plan Model of Care addresses the needs of all sub-populations found in the Molina Medicare SNP.
2. **Care Management Goals** – Utilization of the Molina SNP extensive network of primary Providers, specialty Providers and facilities, in addition to services from the Molina Medicare SNP ICT, will improve access of Molina Members to essential services such as physical health, behavioral health and social services. Molina demonstrates its compliance with this goal using the following data to see annual improvement compared to benchmarks:
 - a. Reports showing availability of services by geographic area;
 - b. Number of Molina SNP Members utilizing the following services:

- Primary Care Provider (PCP) Services
 - Specialty (including Behavioral Health) Services
 - Inpatient Hospital Services
 - Skilled Nursing Facility Services
 - Home Health Services
 - Behavioral Health Facility Services
 - Durable Medical Equipment Services
 - Emergency Department Services
 - Supplemental transportation benefits
 - LTSS
 - c. HEDIS® use of services reports;
 - d. Member Access Complaint Report;
 - e. Medicare CAHPS® Survey; and
 - f. Molina Provider Access Survey.
3. **Members of the Molina SNP will have access to quality affordable healthcare.** Since Members of the Molina SNP are full dual eligible for Medicare and Medicaid, they are not subject to out of pocket costs or cost sharing for covered services. Molina focuses on delivering high quality care. Molina has an extensive process for credentialing network Providers, ongoing monitoring of network Providers and peer review for quality of care complaints. Molina maintains recommended clinical practice guidelines that are evidence based and nationally recognized. Molina regularly measures Provider adherence to key provisions of its clinical practice guidelines. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:
- a. HEDIS® report of percent Providers maintaining board certification;
 - b. Serious reportable adverse events report;
 - c. Annual report on quality of care complaints and peer reviews;
 - d. Annual PCP medical record review;
 - e. Clinical Practice Guideline Measurement Report;
 - f. Licensure sanction report review; and
 - g. Medicare/Medicaid sanctions report review.
4. By having access to Molina’s network of primary care and specialty Providers as well as Molina’s programs that include Care Management Service Coordination, Nurse Advice Line, Utilization Management and Quality Improvement, **SNP Members have an opportunity to realize improved health outcomes.**
- Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:
- a. Medicare HOS; and
 - b. Chronic Care Improvement Program Reports.
5. **Molina Members will have an assigned point of contact for their coordination of care.** According to Member’s need, this coordination of care contact point might be their Molina Network PCP or Molina Case Manager. Care will be coordinated through a single point of contact who interact with the ICT to coordinate services as needed.

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

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

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

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

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

9. **Staff Structure and Roles** - The Molina Medicare SNP has developed its staff structure and roles to meet the needs of dual eligible Special Needs Plan Members. Molina's background as a provider of Medicaid Managed Care services in the states that it serves allows the plan to have expertise in both the Medicare and Medicaid

benefits that Members have access to in the Molina Medicare Dual Eligible SNP. Molina has many years of experience managing this population of patients within Medicaid to go with its experience of managing the Medicare part of their benefit. Molina's Member advocacy and service philosophy is designed and administered to assure Members receive value-added coordination of health care and services that ensures continuity and efficiency and that produces optimal outcomes. Molina employed staff are organized in a manner to meet this objective and include:

- **Care Management Team** that forms a main component of the interdisciplinary care team (ICT) comprised of the following positions and roles:
 - i. Care Review Processors – Gather clinical information about transitions in care and authorizations for services, authorize services within their scope of training and job parameters based upon predetermined criteria, serve as a resource for nursing staff in collecting existing clinical information to assist nursing assessments and care team coordination.
 - ii. Care Review Clinicians (LPN/RN) – Assess, authorize, coordinate and evaluate services, including those provided by specialists and therapists, in conjunction with the Member, Providers and other team members based on Member's needs, medical necessity and predetermined criteria.
 - iii. Case Managers (RN, SW) – Identify and address issues regarding Member's medical, behavioral health care and social needs. Provide care coordination and assistance in accessing community and social service resources as appropriate. Develop a care plan with Member that focuses on Member's identified needs and personal goals. Assist Members, caregivers and Providers in Member transitions between care settings, including facilitation of information retrieval from ancillary Providers, consultants, and diagnostic studies for development, implementation and revision of the care plan.
 - iv. Complex Case Managers (RN, SW) – Identify care needs through ongoing clinical assessments of Members identified as high risk or having complex needs. Activities include coordinating services of medical and non-medical care along a continuum rather than episodic care focused on a Member's physical health care, behavioral health care, chemical dependency services, long term care, and social support needs while creating individualized care plans. Conduct health assessments and manage Member's medical, psychosocial, physical and spiritual needs – develop, implement, monitor and evaluate care plans in conjunction with Members/caregivers, their Providers and other team members. Focus is on Members with complex medical illness.
 - v. Health Manager – Develop materials for Health Management programs. Serve as resource for Members and Molina staff members regarding Health Management Program information, educates Members on how to manage their condition.

- vi. Transitions of Care Coach – The Transitions of Care Coach functions as a facilitator of interdisciplinary collaboration across the transition, engaging the Member and family caregivers to participate in the formation and implementation of an individualized care plan including interventions to mitigate the risk of an avoidable re-hospitalization. The primary role of the Care Transitions Coach is to encourage self-management and direct communication between the Member and Provider rather than to function as another health care Provider.
 - vii. Community Connectors/Health Workers – the Community Connectors are community health workers trained by Molina to serve as Member navigators and promote health within their own communities by providing education, advocacy and social support. Community Connectors also help Members navigate the community resources and decrease identified barriers to care.
 - viii. Behavioral Health Team includes Molina employed clinical behavioral health specialists to assist in behavioral health care issues. A board-certified Psychiatrist functions as a Behavioral Health Medical Director and as a resource for the Integrated Care Management and Care Access and Monitoring Teams and providers regarding Member’s behavioral health care needs and care plans.
- a. **Member & Provider Contact Center (M&PCC)** – Serves as a Member’s initial point of contact with Molina and main source of information about utilizing the Molina Medicare SNP benefits and is comprised of the following positions:
- i. Member Services Representative – Initial point of contact to answer Member questions, assist with benefit information and interpretation, provide information on rights and responsibilities, assist with PCP selection, advocate on Members’ behalf, assist Members with interpretive/translation services, inform and educate Members on available services and benefits, act as liaison in directing calls to other departments when necessary to assist Members.
 - ii. Member Services Managers/Directors – Provide oversight for member services programs, provide and interpret reporting on member services functions, evaluate member services department functions, identify and address opportunities for improvement.
- b. **Appeals and Grievances Team** that assists Members with information about and processing of appeals and grievances:
- i. Appeals and Grievances Coordinator – Provide Member with information about appeal and grievance processes, assist Members in processing appeals and grievances, notifies Members of appeals and grievance outcomes in compliance with CMS regulations.
 - ii. Appeals and Grievances Manager – Provide oversight of appeals and grievance processes assuring that CMS regulations are followed,

provide and interpret reporting on A&G functions, evaluate A&G department functions, identify and address opportunities for improvement.

- c. **Quality Improvement Team** that develops, monitors, evaluates and improves the Molina Medicare SNP Quality Improvement Program. QI Team is comprised of the following positions:
 - i. QI Specialist – Coordinate implementation of QI Program, gather information for QI Program reporting and evaluations, provide analysis of QI Program components.
 - ii. QI Managers/Directors – Development and oversight of QI Program which includes program reporting and evaluation to identify and address opportunities for improvement.
 - iii. HEDIS[®] Specialist – Gather and validate data for HEDIS[®] reporting.
 - iv. HEDIS[®] Manager – Oversight and coordination of data gathering and validation for HEDIS[®] reporting, provide and interpret HEDIS[®] reports, provide preventive services missing services report.
- d. **Medical Director Team** has employed board-certified physicians. Medical Directors and Healthcare Services Program Manager - Responsible for oversight of the development, training and integrity of Molina’s Medicare SNP Healthcare Services and Quality Improvement programs. Resource for Integrated Care Management and Care Access and Monitoring Teams and providers regarding Member’s health care needs and care plans. Selects and monitors usage of nationally

recognized medical necessity criteria, preventive health guidelines and clinical practice guidelines.

- **Behavioral Health Team** has Molina employed health specialists to assist in behavioral health care issues:
 - i. Psychiatrist Medical Director – Responsible for oversight of the development and integrity of behavioral health aspects of Molina’s Medicare SNP Healthcare Services and Quality Improvement programs. Resource for Integrated Care Management and Care Access and Monitoring Teams and Providers regarding Member’s behavioral health care needs and care plans. Develops and monitors usage of behavioral health related medical necessity criteria and clinical practice guidelines.
- **Pharmacy Team** has employed pharmacy professionals that administer the Part D benefit and assist in administration of Part B pharmacy benefits.
 - i. Pharmacy Technician – Serves as point of contact for Members with questions about medications, pharmacy processes, and pharmacy appeals and grievances.

- ii. Pharmacist – Provide authorizations for Part D medications. Provide oversight of pharmacy technician performance, resource for Care Management Teams, other Molina staff and Providers, provide review of post discharge medication changes, review Member medication lists and report data to assure adherence and safety, interact with Members and Providers to discuss medication lists and adherence.
- **Healthcare Analytics Team**
 - i. Healthcare Analysts – Assist in gathering information, developing reports, providing analysis for health plan to meet CMS reporting requirements, evaluate the model of care and review operations.
 - ii. Director Healthcare Analytics – Develop predictive modeling programs used to assist in identifying Members at risk for future utilization, oversight of healthcare reporting and analysis program, oversight of clinical aspects of Part C Quality Reporting, oversight of healthcare analysts.
 - **Health Management Team** is a Molina care team that provides multiple services to Molina’s Medicare SNP Members. This team provides population-based Health Management Programs for low risk Members identified with asthma and depression. The Health Management team also provides a twenty-four/seven (24/7) Nurse Advice Line for Members, outbound post hospital discharge calls and outbound preventive services reminder calls. The Health Management team is comprised of the following positions:
 - a. Medicare Member Outreach Assistant – Make outbound calls related to gathering and giving information regarding Health Management programs, make outbound calls to review whether Member received hospital discharge plan, make referrals to Care/Case Managers when Members have questions about their hospital discharge plan, make outbound preventive service reminder calls.
 - b. Nurse Advice Line Nurse – Receive inbound calls from Members and Providers with questions about medical care and after-hours issues that need to be addressed, give protocol based medical advice to Members, direct after-hours transitions in care.
 - **Interdisciplinary Care Team**
 - a. Composition of the Interdisciplinary Care Team

The following is a description of the composition of the ICT and how membership on the team is determined. The Molina Medicare SNP Interdisciplinary Care Team (ICT) is the core of Molina’s Integrated Care Management Program. Molina chooses ICT membership based on those health care professionals who have the most frequent contact with the Members and the most ability to implement Model of Care components in the Member’s care. The ICT is typically composed of the Member’s assigned PCP, the Molina assigned Case Manager and Molina Medical Director. The Member can select other participants

such as their caregiver, specialist or family. The composition of this team is designed to address all aspects of a Member's healthcare including medical, behavioral, and social health. Additional members of the ICT may be added on a case by case basis depending on a Member's conditions and health status.

- b. Additional positions that may be included (either temporarily or permanently) to the Molina Medicare SNP ICT caring for Members include:
 - Molina Medical Directors
 - Molina Behavioral Health Specialists
 - Molina Pharmacists
 - Molina Care Transitions Coaches
 - Molina Community Connectors/Health Workers
 - Network Medical Specialty Providers
 - Network Home Health Providers
 - Network Acute Care Hospital Staff
 - Network Skilled Nursing Facility Staff
 - Network Long Term Services and Supports Staff
 - Network Certified Outpatient Rehabilitation Staff
 - Network Behavioral Health Facility Staff
 - Network Renal Dialysis Center Staff
 - Out of Network Providers or Facility Staff (until a Member's condition of the state of the Molina Network allows safe transfer to network care)

- c. Adding Members to the ICT will be considered when:
 - Member has been stratified to a Level 3 (Complex Case Management, Care Management Level) in the assessment process.
 - Member is undergoing a transition in healthcare setting.
 - Member sees multiple medical specialists for care on a regular and ongoing basis.
 - Member has significant complex or unresolved medical diagnoses.
 - Member has significant complex or unresolved mental health diagnoses.
 - Member has significant complex or unresolved pharmacy needs.

- d. Molina's Medicare SNP Members and their caregivers participate in the Molina ICT through many mechanisms including:
 - Discussions about their health care with their PCP,
 - Discussions about their health care with medical specialists or ancillary Providers who are participating in the Member's care as directed by the Member's PCP.
 - Discussions about their health care with facility staff who are participating in the Member's care as directed by the Member's PCP.
 - During the assessment process by Molina Staff.
 - Discussions about their health care with their assigned Molina Integrated Care Management Team members.

- Discussions with Molina Staff in the course of Health Management programs, preventive healthcare outreach, Care Transitions program and other post hospital discharge outreach.
- Discussion with Molina Pharmacists about complex medication issues.
- Through the appeals and grievance processes.
- By invitation during case conferences or regular ICT meetings.
- By request of the Member or caregiver to participate in regular ICT meetings.

e. ICT Operations and Communication

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

- f. The Integrated Care Management Team will be primarily involved during assessment periods, individualized care plan follow-up, transitions of care settings, routine case management follow-up, and significant changes in the Member's health status. In addition, the Care management team will be involved after referral from other Molina Staff (i.e., Utilization Management staff, Pharmacists), requests for assistance from PCPs, requests for assistance from Members/caregivers. Transitions in care and significant changes in health status that need follow-up will be detected when services requiring prior authorization are requested by the Member's PCP or other Providers (signaling a transition in care or complex medical need). The PCP and Integrated Care Management Team will decide when additional ICT meetings are necessary and will schedule them on "as needed" basis.
- g. The ICT will hold regular case conferences for Members with complex healthcare needs and/or complex transition issues. Members will be chosen for case conferences based on need as identified by the Molina Integrated Care Management Team, when referred by their Provider or at the request of the Member/caregiver. All members of the ICT will be invited to participate in the case conference. Members and/or their caregivers will be invited to participate when feasible. The ICT will keep minutes of the case conferences and will provide a case conference summary for each Member case discussed. Case conference

summaries will be provided to all ICT members and the involved Member/caregiver.

- h. Communication between ICT members will be compliant with all applicable HIPAA regulations and will occur in multiple ways including:
 - o Integrated Care Management Team to acquire and review Member's medical records from Providers on the ICT before, during and after transitions in care and during significant changes in the health status of Members.
 - o Integrated Care Management Team to acquire and review Member's medical records from Provider members of the ICT during authorization process for those medical services that require prior authorization:
 1. Integrated Care Management Team to acquire and review Member's medical records from Provider members of the ICT during the course of regular case management activities
 2. Verbal or written communication between PCP and Integrated Care Management Team may occur during PCP participation in ICT Case Conferences on an as needed basis.
 3. Written copies of assessment documents from Integrated Care Management Team to PCP by request and on an as needed basis.
 4. Written copies of individualized care plan from Integrated Care Management Team to PCP (and other Providers as needed).
 5. Case conference summaries.
 - o Member care plans are reviewed at least annually by professional clinical Molina staff members in conjunction with annual Comprehensive Health Risk Assessments. Additional opportunities for review and revision of care plans may exist when Molina Integrated Care Management Team members are aware of Member transitions in healthcare settings or significant changes in Member health care status.
 - o The plan of care is documented, reviewed and revised in the Clinical Care Advance system using template driven data entry to assure accuracy and completeness of care plans.

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

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

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

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

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

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

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

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

The Member's PCP is primarily responsible for determining what medical services a Member needs. For Members receiving treatment primarily through specialist physician, the specialist may be primarily responsible for determining needed medical services. The PCP is assisted by the Molina Care Management Team, medical specialty consultants, ancillary Providers, mental/behavioral health Providers and Members or their caregivers in making these determinations. For

Members undergoing transitions in healthcare settings, facility staff (hospital, SNF, home health, etc.) may also be involved in making recommendations or assisting with access to needed services. For those services that require prior authorization the Molina Care Management Team will assist Providers and Members in determining medical necessity, available network resources (and out of network resources where necessary). The Molina Care Management portion of the ICT will assist in finding access when difficulties arise for certain services.

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

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

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

Reports on services delivered will be maintained by the ICT primarily in the PCP medical record. The Molina Medicare SNP regularly audits the completeness of PCP medical records utilizing the annual PCP Medical Record Review process. The Molina Care Management Team will document relevant clinical notes on services and outcomes in QNXT and Clinical Care Advance platforms as appropriate to document significant changes in the Member's healthcare status or healthcare setting and to update care plans. A copy of the care plan will be provided to the PCP.

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

The Molina Medicare SNP will use nationally recognized, evidence based clinical practice guidelines. Molina Medical Directors will select clinical practice guidelines

that are relevant to the SNP population. These clinical practice guidelines will be communicated to Providers utilizing Provider newsletter and the Molina website. Molina will annually measure Provider compliance with important aspects of the clinical practice guidelines and report results to Providers.

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

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

12. **Communication** - Molina will monitor and coordinate care for Members using an integrated communication system between Members/caregivers, the Molina ICT, other Molina staff, Providers and CMS. Communications structure includes the following elements:
 - Molina utilizes state of the art telephonic communications systems for telephonic interaction between Molina staff and all other stakeholders with capabilities for call center queues, call center reporting, computer screen sharing (available only to Molina staff) and audio conferencing. Molina maintains Member and Provider services call centers during CMS mandated business hours and a Nurse Advice Line (after hours) that Members and Providers may use for communication and inquiries. Interactive voice response systems may be used for Member assessment data gathering as well as general healthcare reminders. Electronic fax capability and Molina's ePortal allow for the electronic transmission of data for authorization purposes and transitions between settings. Faxed and electronic information is maintained in the Member's Molina record.
 - For communication of a general nature Molina uses newsletters (Provider and Member), the Molina website and blast fax communications (Providers only). Molina may also use secure web-based interfaces for Member assessment, staff training, Provider inquiries and Provider training.

- For communication between Members of the ICT, Molina has available audio conferencing and audio video conferencing (Molina staff only). Most regular and ad-hoc ICT care management meetings will be held on a face-to-face basis with PCPs, other Providers and Member/caregivers joining via audio conferencing as needed.
- Written and fax documentation from Members and Providers (clinical records, appeals, grievances) when received will be routed through secure mail room procedures to appropriate parties for tracking and resolution.
- Email communication may be exchanged with Providers and CMS.
- Direct person-to-person communication may also occur between various stakeholders and Molina.
- Molina Quality Improvement Committees and Sub-Committees will meet regularly on a face-to-face basis with Committee Members not able to attend in person attending via audio conferencing.

Tracking and documentation of communications occurs utilizing the following:

- a. The QNXT call tracking system will be used to document all significant telephonic conversations regarding inquiries from Members/caregivers and Providers. All telephonically received grievances will be documented in the QNXT call tracking system. QNXT call tracking allows storage of a record of inquiries and grievances, status reporting and outcomes reporting.
 - b. Communication between ICT Members and/or stakeholders will be documented in QNXT call tracking, QNXT clinical modules or Clinical Care Advance as appropriate. This documentation allows electronic status tracking and archiving of discussions. Written meeting summaries may be used when issues discussed are not easily documented using the electronic means documented above.
 - c. Written and faxed communications when received are stored in an electronic document storage solution and archived to preserve the data. Written documents related to appeals and grievances result in a call tracking entry made in QNXT call tracking when they are received allowing electronic tracking of status and resolution.
 - d. Email communication with stakeholders is archived in the Molina email server.
 - e. Direct person-to-person communication will result in a QNXT call tracking entry or a written summary depending on the situation.
 - f. Molina Committee meetings will result in official meeting minutes which will be archived for future reference. A designated Molina Quality Improvement Director will have responsibility to oversee, monitor and evaluate the effectiveness of the Molina Medicare SNP Communication Program.
13. **Performance and Health Outcomes Measurement** - Molina collects, analyzes reports and acts on data evaluating the Model of Care. To evaluate the Model of Care, Molina may collect data from multiple sources including:
- a. Administrative (demographics, call center data)
 - b. Authorizations

- c. CAHPS®
- d. Call Tracking
- e. Claims
- f. Clinical Care Advance (Care/Case/Disease Management Program data)
- g. Encounters
- h. HEDIS®
- i. HOS
- j. Medical Record Reviews
- k. Pharmacy
- l. Provider Access Survey
- m. Provider Satisfaction Survey
- n. Risk Assessments
- o. Utilization
- p. SF12v2™ Survey Results
- q. Case Management Satisfaction Survey

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

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

Molina will submit CMS required public reporting data including:

- HEDIS® Data
- SNP Structure and Process Measures
- Health Outcomes Survey
- CAHPS® Survey

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

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

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

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

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

Specific add-on services of most use to vulnerable sub-populations include:

- c. Case management;
- d. Disease management; and/or
- e. Provider home visits.

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

Chapter 8 - Member Rights and Responsibilities

STAR and STAR+PLUS Member Rights and Responsibilities

- You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
 - Be treated fairly and with respect
 - Know that your medical records and discussions with your providers will be kept private and confidential.
- You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
 - Be told how to choose and change your health plan and your primary care provider.
 - Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
 - Change your primary care provider.
 - Change your health plan without penalty.
 - Be told how to change your health plan or your primary care provider.
- You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
 - Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated,
 - Be told why care or services were denied and not given.
- You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
 - Work as part of a team with your provider in deciding what health care is best for you.
- You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
 - a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
 - b. Get a timely answer to your complaint.
 - c. Use the plan's appeal process and be told how to use it.
 - d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
- e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

- Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need-
 - Get medical care in a timely manner.
 - Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limits mobility, in accordance with the Americans with Disabilities
 - Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone assist with a disability, or help you understand the information.
 - Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
- You have the right not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do, or is to punish you.
 - You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
 - You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

MEMBER RESPONSIBILITIES:

- You must- learn and understand each right you have under the Medicaid program. That includes the responsibility to:
 - Learn and understand your rights under the Medicaid program.
 - Ask questions if you do not understand your rights
 - Learn what choices of health plans are available in your area.
- You must- abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
 - Learn and follow your health plan's rules and Medicaid rules.
 - Choose your health plan and a primary care provider quickly.
 - Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
 - Keep your scheduled appointments
 - Cancel appointments in advance when you cannot keep them
 - Always contact your primary care provider first for your non-emergency medical needs.
 - Be sure you have approval from your primary care provider before going to a specialist.
 - Understand when you should and should not go to the emergency room.
- You must share information about your health with your primary care provider and other providers and learn about service and treatment options. That includes the responsibility to:
 - Tell your primary care provider about your health in order for them to continue to provide care that they need for you

- Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
- Help your providers get your medical records.
- You must be involved- in decisions relating to service and treatment options, make personal choices, and take action to maintain your health.
 - Work as a team with your provider in deciding what health care is best for you.
 - Understand how the things you do can affect your health.
 - Do the best you can to stay healthy.
 - Treat providers and staff with respect.
 - Talk to your provider about all of your medication

Additional Member Responsibilities while using NEMT Services

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible

CHIP MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS:

- You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
- Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."

- You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
- You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
- You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
- You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
- If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
- Children who are diagnosed with special health care needs or a disability have the right to special care.
- If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
- Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
- Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members.
- You have the right and responsibility to take part in all the choices about your child's health care.
- You have the right to speak for your child in all treatment choices.
- You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
- You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
- You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
- You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

- You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
- You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

- You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
- You must become involved in the doctor's decisions about your child's treatments.
- You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
- If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
- You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
- If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
- If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
- You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
- Talk to your child's provider about all of your child's medications.

CHIP PERINATE MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS:

- You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
- You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.

- You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
- You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
- You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
- You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
- You have the right and responsibility to take part in all the choices about your unborn child's health care.
- You have the right to speak for your unborn child in all treatment choices.
- You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
- You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
- You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
- You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.

6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. Talk to your provider about all of your medications.

ATTENTION FEMALE MEMBERS:

You have the right to select an OB/GYN without a referral from your PCP. The access to health care services of an OB/GYN includes:

- one well-woman check-up per year
- care related to pregnancy
- care for any female medical condition, and
- referral to specialist doctor within the network

Members' Right to Designate an OB/GYN (STAR, STAR+PLUS, & CHIP)

Females may request an OB/GYN be their PCP, especially during their pregnancy. If the OB/GYN agrees to be the PCP, the physician must refer the Member if care outside of their scope of expertise is required. A certified nurse midwife may act as a PCP only during and immediately after a women's pregnancy. Otherwise, specialists may serve as PCPs only as set forth. All PCPs must have admitting privileges to a hospital within the Molina network.

If a member is pregnant when she/her daughter start coverage with Molina and are seeing a doctor that is not a Molina doctor, she/her daughter can still see that doctor if she/her daughter are in the second or third trimester of the pregnancy, or have a health problem that would make changing to a new doctor unsafe. Otherwise, she/her daughter will need to pick a doctor from the Molina Provider Directory for care.

Women's Health Access

Molina allows Members the option to seek obstetrical and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina Healthcare of Texas, Inc. 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 QI Department toll free at (855) 322-4080.

Indian Health Care Providers

Indian Members may designate a Network Indian Health Care Provider (IHCP) as Primary Care Provider, as long as the provider had the capacity to provide the necessary services. Indian Members may receive Covered Services from an Out-of-Network IHCP from whom the Indian Member is otherwise eligible to receive such services.

Access to Ophthalmologists or Therapeutic Optometrist

You have the right to select and have access to, without a Primary Care Provider referral, a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery.

Member's Right to Obtain Medication

You have the right to obtain medication from any Network Pharmacy.

Chapter 9 - Provider Roles and Responsibilities

(STAR, STAR+PLUS, MMP & CHIP)

Nondiscrimination of Healthcare Service Delivery

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

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care. Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they receive assistance with Medicare cost sharing from a State Medicaid Program.

Section 1557 Investigations

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

Molina Healthcare
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90807
Toll Free: (866) 606-3889
TTY/TDD: 711

Online: <https://molinahealthcare.AlertLine.com>
Email: civil.rights@molinahealthcare.com

Provider Responsibilities

PCP Duties and Responsibilities

The PCP must provide a medical home to Members. The PCP must provide primary care to patients, maintain the continuity of patient care, and initiate and manage referrals for specialized care. Included within that responsibility are the following obligations:

- Verifying eligibility;
- Supervising, coordinating and providing initial and basic care to Members;
- Initiating and authorizing their referral for specialist care, inpatient care, and other Medically Necessary services;
- Following Members admitted to Inpatient Facilities; and
- Maintaining continuity of Member care.

Primary care services are all medical services required by a Member for the prevention, detection, treatment and cure of illness, trauma, or disease, which are covered and/or required services under the Texas Medicaid and CHIP program as required by State and/or federal guidelines.

The PCP must ensure that Members under the age of 21 receive all services required by HHSC including but not limited to the American Academy of Pediatrics (AAP) recommended schedule for CHIP Members and the THSteps periodicity schedule, published in the THSteps Manual, for Medicaid Members. Adults must be provided with preventive services in accordance with the U.S. Preventative Task Force requirements. All services must be provided in compliance with all generally accepted medical standards for the community in which services are rendered.

Note: Network Providers who are Primary Care Physicians must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. A Primary Care Physician may provide behavioral health related services within the scope of his/her practice. Resources for identifying, screening for, referral to and/or treating mental health, substance use, and developmental disorders can be located at www.MolinaHealthcare.com.

Specialty Care Provider Responsibilities

Some specialty services require a referral from the PCP. The Specialist may order diagnostic tests without PCP involvement; however, the Specialist may not refer to another specialist except in a true emergency situation. Specialists must abide by the referral and authorization guidelines as described in “What Requires Authorization.”

The Specialist provider must:

- Verify eligibility,
- Obtain referral or authorization from the PCP before providing certain services;
- Not refer the member to another specialist provider, except in a true emergency situation
- Provide the PCP with consultation reports and other appropriate records in a timely manner;
- Participate in the Peer Review Process and be available for or provide on call coverage through another source 24 hours a day;
- Maintain regular hours of operation that are clearly defined and communicated to members; and
- Provide urgent specialty care within 24 hours of request.

Long Term Services & Support Provider Responsibilities

Long term services and support providers are responsible for:

- Verifying member eligibility prior to performing services;
- Adhering to the Molina Healthcare authorization policies;
- Medicaid/Medicare coordination
- Determining if members have medical benefits through other insurance coverage, including Dual eligibles;
- Ensuring that there is ongoing continuity of care between the member's Molina Healthcare coordinator and the PCP; and
- Notifying the plan whenever there is change in the member's physical or mental condition and/or a change in their eligibility;

Long Term Services & Support Role

Molina's Service Coordinators are responsible for authorizing approved services for Long Term Care providers. The Provider must submit an authorization request with all appropriate CPT and ICD codes along with the company and member information, including dates requested to the Molina Service Coordination department. If an authorization requires utilization management's intervention, it may take up to 5 days for the authorization to be returned. All authorizations that are sent to the provider will have specific dates and services that have been approved and are always based upon member enrollment at the time services are rendered. Verbal authorizations will not be given.

Early Childhood Intervention Case Management/Service Coordination and the Case Management for Children and Pregnant Women Providers

Early Childhood intervention (ECI) Comprehensive Care Program (CCP)

The Early Childhood Intervention (ECI) and the Comprehensive Care Program (CCP) programs are part of Medicaid managed benefits. ECI and CCP Providers must submit claims to Molina for reimbursement. Providers are responsible for:

- Verifying member eligibility prior to performing services and
- Adhering to the Molina Healthcare authorization policies.

Pharmacy Provider Responsibilities

- Adhere to the Formulary
- Adhere to the Preferred Drug List (PDL)
- Coordinate with the prescribing physician
- Ensure Members receive all medications for which they are eligible
- Coordinate benefits when a Member also receives Medicare Part D services and other benefits

Note: STAR+PLUS Members who are dually eligible for Medicare will receive most prescription drug services through Medicare rather than Medicaid. The STAR+PLUS Program does cover a limited number of medications not covered by Medicare.

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

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

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact Member access to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

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

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

Please visit our Provider Online Directory at <https://providersearch.molinahealthcare.com> to validate and correct most of your information. A convenient web form can be found on the POD and on the Provider Portal at <https://provider.MolinaHealthcare.com>. You can also notify your Provider Services Representative **and** submit the Provider Change of Information form located at www.MolinaHealthcare.com under the Provider Forms section if your information needs to be updated or corrected.

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

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

Network providers must inform both the MCO and HHSC's administrative services contractor of any changes to the providers' address, telephone number, group affiliation, etc.

Molina Electronic Solutions Requirements

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

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

Molina also strongly encourages the submission of electronic claims, which includes claims submitted via a clearinghouse using the EDI process and claims submitted through the Molina Provider Web Portal.

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for Molina's Provider Web Portal within thirty (30) days of entering the Molina network.

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

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- Provider Portal

Electronic Claims Submission

Molina strongly encourages Participating Providers to submit claims electronically whenever possible. 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 via the Provider Portal. See our Provider Portal Quick Reference Guide <https://provider.molinahealthcare.com> or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 20554, refer to our website www.molinahealthcare.com for additional information.

While both options are embraced by Molina, submitting claims via Molina's Provider 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.

Provider Portal Claims submitting benefits include:

- Add attachments to claims
- Submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim
- Ability to Save incomplete/un-submitted Claims
- Create/Manage Claim Templates

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

Electronic Payment (EFT/ERA) Requirement

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

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

Any questions during this process should be directed to Change Healthcare Provider Services at wco.provider.registration@changehealthcare.com or 877-389-1160.

Provider Portal

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

- Verify and print Member eligibility
- View benefits, covered services and Member Health record
- View roster of assigned Molina members for PCP(s)
- Claims Functions
 - Professional and Institutional Claims (individual or multiple claims)
 - Receive notification of Claims status change
 - Correct Claims
 - Void Claims
 - Add attachments to previously submitted claims
 - Check Claims status
 - Export Claims reports
 - Create and Manage Claims Templates
 - Open Saved Claims
- Prior Authorizations/Service Requests
 - Create and submit Service/Prior Authorization Requests
 - Check status of Service/Authorization Requests
 - Receive notification of change in status of Service/Authorization Requests
 - Create Service Request/Authorization Templates
- View HEDIS® Scores and compare to national benchmarks
- Appeals
 - Create and submit a Claim Appeal
 - Add Appeal attachments to Appeal
 - Receive Email Confirmation

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

Electronic Processes and Initiatives & the Medicare Quality Bonus Payment Programs

In an effort to streamline the exchange of claim and payment information, Member's medical records, and to promote Molina Healthcare's Provider Web-Portal we are amending our contracts to prepare for the delivery of key health plan updates via electronic systems, including our website and interactive web portal, and formally update the Medicare Quality Bonus Payment Program.

As a result of these changes, the Quality Bonus Payment Program will be presented on the Molina Healthcare Provider Web-Portal. The purpose of this is to provide this program universally to all qualified primary care groups. Information regarding the eligibility, criteria, and quality initiatives can be found on the Molina Healthcare Provider Web-Portal. If your

agreement previously contained the Medicare Quality Partner Program, this attachment will be terminated effective at the end of this year.

In accordance with the applicable provisions of the Provider or Combined Provider Services Agreement, or other corresponding health care services agreement or applicable contract, by and between Molina Healthcare of Texas and contracted providers (the "Agreement"), you are hereby being provided with an Amendment promoting Molina Healthcare's electronic processes and initiatives and establishing quality bonus payment program(s).

Please contact Provider Services by phone at (855) 322-4080 or by email at mhtxproviderservices@molinahealthcare.com if you have any questions regarding Molina Healthcare or this Amendment.

Balance Billing

Providers contracted with Molina cannot bill the Member for any covered benefits beyond applicable copayments, deductibles, or coinsurance (Note: there are **no** copayments, deductibles or coinsurance for Medicaid members). The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

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

For additional information, please refer to the Compliance and Billing Section of this Provider Manual.

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 in this Provider Manual.

Member Information and Marketing

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

Member Eligibility Verification

Possession of a Molina ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

For additional information, please refer to the Member Eligibility section of this Manual.

Member Cost Share

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

Provider Termination and Dismissal

Providers may terminate their agreement with Molina Healthcare after providing a sixty (60) days written notice in the event that provider rejects any written material modification to policies, procedures or products, provided the notice is received no later than 30 days from the date the provider received the notification.

Request to Discharge a Member

It may become necessary for a PCP to discharge a member from his/her panel. Prior to discharging a member, the primary care physician must counsel the patient regarding the patient/physician relationship. Such counseling must be documented appropriately in the medical chart, an incident report or treatment plan. If the behavior does not improve, the PCP may request in writing to the Plan, the member be dismissed from his/her panel. The Member Services department will send written notification to the member advising them to select a new PCP.

The PCP is required to continue treating the member for 30 days following the notification to the member.

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, and Medical Necessity review determination 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 Healthcare Services section of this Provider Manual.

In Office Laboratory Tests

Molina Healthcare'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 www.molinahealthcare.com.

For more information about In-Network Laboratory Providers, please consult the Molina Provider Online Directory (<https://providersearch.molinahealthcare.com/>). For testing

available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient services centers, please reach out to the In-Network Laboratory Provider.

Specimen collection is allowed in a physician's office and shall be compensated in accordance with your agreement with Molina Healthcare and applicable state and federal billing and payment rules and regulations.

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

Referrals

A referral is necessary when a Provider, including substance abuse treatment providers, determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals, unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and Specialist to coordinate care of the patient to ensure continuity of care. Providers need to document 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 Healthcare Medicaid, CHIP and MMP. In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including but not limited to primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out of network Provider. Prior authorization will be required from Molina except in the case of Emergency Services. For additional information, please refer to the Healthcare Services section of this Provider Manual.

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

If PCP believes that a Member needs to be referred to an Out-of-Network provider, including medical partners not contracted with Molina, documentation demonstrating the need must be submitted to Molina Healthcare for review and prior authorization before the referral can occur. There must be documentation of coordination of referrals and services provided between the Primary Care Provider and Specialist.

Members with disabilities, special health care needs, chronic or complex conditions, or who are in Nursing Facilities, have the right to designate a specialist as their PCP as long as the specialist agrees.

Referrals to Network Facilities and Contactors

Referrals to network facilities and contractors do not require a prior authorization except as specifically noted on the current Prior Authorization Guide.

Admissions for Inpatient Hospital Care

The Provider must maintain admitting privileges with a Molina participating hospital or make arrangements with another Texas licensed physician who is an eligible Medicaid provider and who maintains admitting privileges with a participating Molina hospital.

Required Notifications

Please note, per the UMCM Chapter 8.1: All Home and Community Support Services Agency (HCSSA) providers, adult day care providers and residential care facility provider must notify the MCO if a member experiences any of the following:

- If a Member is at risk of institutionalization, providers will use best efforts to notify plan within 24 hours.
- If a Member has a change in condition, Providers shall use best efforts to notify Health Plan within 24 hours.
- If a member is hospitalized, providers shall use best efforts to notify the Health Plan within 24 hours of admission.
- If a Member has emergency room visit, Providers shall use best efforts to notify Health Plan within 24 hours.
- If a Member has two or more missed appointments, providers will use best efforts to notify Health Plan of two or more missed appointments by member.

Coordination with Texas Department of Family & Protective Services (TDFPS)

Molina works with TDFPS to ensure children in custody, or under the supervision, of TDFPS receive needed services. The needs of this population are special in that children will transition in and out of care more frequently than the general population.

Providers must:

- Coordinate with TDFPS and the Foster parents for the care of a child who is receiving services from, or has been placed in the conservatorship of TDFPS and respond to requests from TDFPS, including providing medical records and recognition of abuse and neglect, and appropriate referral to TDFPS
- Schedule medical and Behavioral Health Services appointments within 14 days unless requested earlier by TDFPS
- Testify in court for child protection litigation
- Refer suspected abuse and neglect to TDFPS

Molina must continue to provide all Covered Services to a Member receiving services from, or in the protective custody of TDFPS until the Member has been disenrolled from Molina due to loss of eligibility or placed into foster care.

Coordination and Referral to Other Health and Community Resources

The PCP must coordinate the care of Members with other Medicaid programs, public health agencies and community resources which provide medical, nutritional, educational, and outreach services to Members, including the Women, Infants and Children Program (WIC), school health clinics, and local health and mental health departments.

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 prescription policies. 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 Improvement section of this Manual.

Molina's Quality Assurance Program and Provider Responsibilities

Molina Healthcare has a comprehensive quality assurance program and will audit and review contracted providers upon its discretion. Providers have the responsibility to report any member fraud, waste, or abuse. Members also have the responsibility to report any provider fraud or abuse via the protocol listed in your provider manual.

The provider Performance program is also listed in this provider manual and will assist providers in highly recognized disease management areas such as Hypertension, Diabetes, Asthma, Hyperlipidemia, and preventing unnecessary waste and over utilization.

Availability and Accessibility/Access to Care Standards

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs (adult and pediatric) and participating specialists (to include OB/GYN, behavioral health providers, and high volume and high impact specialist). 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 (90%) availability for Emergency Services and ninety percent (90%) or greater for all other services. The PCP or his/her designee must be available twenty-four (24) hours a day,

seven (7) days a week to Members for Emergency Services. This access may be by telephone.

Emergency and After-Hours Access

All providers must have back-up (on call) coverage after hours or during the Provider’s absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour telephone service, seven (7) days a week.

The following are acceptable and unacceptable telephone arrangements for contracted PCPs after their normal business hours:

Acceptable after-hours coverage

- The office telephone is answered after-hours by an answering service, which meets language requirements of the Major Population Groups and which can contact the PCP or another designated medical practitioner.
- All calls answered by an answering service must be returned within 30 minutes;
- The office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the patient to call another number to reach the PCP or another provider designated by the PCP.
- Someone must be available to answer the designated provider’s telephone. Another recording is not acceptable.
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable after-hours coverage

- The office telephone is only answered during office hours;
- The office telephone is answered after-hours by a recording that tells patients to leave a message;
- The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and
- Returning after-hours calls outside of 30 minutes.

Appointment Availability/Waiting Times for Appointments (Medicaid and CHIP)

All providers who oversee the Member’s health care are responsible for providing the following appointments to Molina Members in the timeframes noted:

Medical Appointment Types	Standard
Primary Routine Exams	Within 14 days
Specialty Routine Exams	Within 21 days
Preventive Health Services for children	Within 60 days
Preventive Health Services for adults	Within 90 days
Urgent Care	Within 24 hours

Treatment for Acute conditions, including specialty services	Within 72 hours
Prenatal Care	Within 14 days
High-Risk Prenatal Care/New Member in Third Trimester	Within 5 days
Texas Health Steps Exams	According to Periodicity Schedule
Behavioral Health Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-life-Threatening Emergency	Within six (6) hours
Urgent Care (must be provided by a licensed Behavioral Health Clinician)	Within twenty-four (24) hours
Routine Care	Within 14 days
Treatment for Acute conditions	Within 72 hours

- Emergency care should be received immediately.
- PCPs should make referrals timely, but no later than 5 days after the visit where the need for a referral was determined
- Referrals to a specialist should be seen within 30 days of a request.

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

Appointment Availability/Waiting Times for Appointments (MMP)

All providers who oversee the health care for Molina Dual Option STAR+PLUS MMP Enrollees are responsible for following the appointment timeframes noted below:

Medical Appointment Types	Standard
Emergency Care	Immediately
Acute/Urgent Care	Within 24 hours
Preventive Care Services	Within five (5) weeks of request
Routine Primary Care Services	Within two (2) weeks of request
Routine Specialty Care Services	Within three (3) weeks of request
Behavioral Health Appointment Types	Standard
Life Threatening Emergency Care	Immediately
Non-life Threatening Emergency Care	Within six (6) hours
Urgent Care	Within 24 hours
Routine Care	Within ten (10) working days of request

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

Additional information on appointment access standards is available from your local Molina Quality Department at (855) 322-4080.

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 at (855) 322-4080.
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; and,
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

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

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-hour access.
2. Member complaint data – assessment of Member complaints related to access to care.

3. Member satisfaction survey – evaluation of Member’s 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.

Medical Record Requirements

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member’s record. PCPs should maintain the following components:

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

Medical Record Keeping Practices

Medical records must contain all aspects of patient care, including ancillary services. Below is a list of the minimum items that are necessary in the maintenance of the Member’s Medical record:

- Each patient has a separate medical record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available at each visit and archived records are available within twenty-four (24) hours.
- If hardcopy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for Quality and 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.

The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.

Content

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

- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact;
- Legible signatures and credentials of provider and other staff members within a paper chart;
- All providers who participate in the member's care;
- Information about services delivered by these providers;
- A problem list is in a prominent space that describes the member's medical and behavioral health conditions.
- Presenting complaints diagnoses, and treatment plans, including follow-up visits and referrals to other providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Allergies and adverse reactions are listed on the front cover of the record or prominently in the inside front page. If the patient has no known allergies, this is appropriately noted.
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with the member, and a copy of Advanced Directives when in place;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- For children under seven (7) years of age, this includes source of history, family medical history, family social history, prenatal care and summary of birth events, developmental history, allergies, medication history, lead exposure, tobacco exposure, safety practices, serious accidents, operations and illnesses.
- Treatment plans are documented and consistent with the diagnosis.
- A working diagnosis is recorded with the clinical findings.
- Pertinent history for the presenting problem;
- Pertinent physical exam for the presenting problem;
- Lab and other diagnostic tests are ordered as appropriate by the practitioner;
- Clear and thorough progress notes that state the intent for all ordered services and treatments;
- Notations regarding follow-up care, calls, or visits. - the specific time of return is noted in weeks, months, or as needed. Include the preventive 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 plans.
- All ancillary service reports;
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report;
- Labor and Delivery Record for any child seen since birth;

- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.
- A release document for each Member authorizing Molina to release medical information for facilitation of medical care.

Retrieval

- The medical record is available to Provider at each Encounter.
- The medical record is available to Molina for purposed of quality improvement.
- The medical record is available to HHSC and the External Quality Review Organization upon request.
- The medical record is available to the Member upon their request.
- A storage system for inactive member medical records which allows retrieval within twenty-four (24) hours, is consistent with State and Federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one (1) year past their 20th birthday, but never less than 10 (ten) years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

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 this is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health and enrollment information,
- Medical records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Molina Quality Department at (855) 322-4080. See also the Compliance Section of this Provider Manual for additional information regarding HIPAA.

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. For additional information, please refer to the Compliance section of this Provider Manual.

All Member information, records and data collected or prepared by the Provider, or provided to the Provider by HHSC or another state agency is protected from disclosure by state and federal laws. The Provider must ensure that all information relating to Members is protected from disclosure except when the information is required to verify eligibility, provide services or assist in the investigation and prosecution of civil and criminal proceedings under state or federal law.

The Provider must inform Members of their right to have their medical records and Medicaid information kept confidential.

The Provider must educate employees and Members concerning the human immunodeficiency virus (HIV) and its related conditions including acquired immunodeficiency syndrome (AIDS), and must develop and implement a policy for protecting the confidentiality of AIDS and HIV- related medical information and an anti-discrimination policy for employees and Members with communicable diseases. See also Health and Safety Code, Chapter 85, Subchapter E, relating to Duties of State Agencies and State Contractors.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records and/or statement if needed. This includes the maintenance and retention of Member records for a period of not less than ten (10) years and retained further if the records are under review or audit until such time that the review or audit is complete.

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

Participation in Credentialing

Providers are required to participate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable accreditation, state and federal requirements.

This includes providing prompt responses to Molina's requests for information related to the credentialing or re-credentialing process.

Providers must notify Molina no less than thirty (30) days in advance when they relocate or open an additional office.

More information about Molina's Credentialing program, including Policies and Procedures, is available in the Credentialing section of this Provider Manual.

Delegation

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

PCP Patient Capacity

There are no limitations on the number of patients a PCP can have assigned to his/her practice; however, all PCP's reserve the right to state the number of patients they are willing to accept into their practice.

If a provider desires to make a change to his/her capacity, the provider must contact the Provider Services Department. If the change request is received between the 1st and the 15th of the month, the change will be effective on the first day of the following month. If the change request is received after the 15th of the month, the change will be effective on the first day of the second month following the request.

Second Opinions

Members or a Member's PCP can request a second opinion on behalf of the Member. If you or a Member requests a second opinion, Molina will give you a decision within 48 hours. If it is an imminent and serious threat, Molina will respond within one (1) day, and the second opinion will be given within seventy-two (72) hours. If a qualified Participating Provider is not available to give the Member a second opinion, Molina will make arrangements for a Non-Participating Provider to give them a second opinion. If Molina denies the second opinion because it is not medically necessary, we will send the Member a letter. Members or Providers may appeal the decision. The letter from Molina will tell you how to appeal.

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 three (3) types of Advance Directives:

- **Durable Power of Attorney for Health Care:** allows an agent to be appointed to carry out health care decisions
- **Living Will:** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration
- **Guardian Appointment:** allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary

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

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

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

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

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

Molina network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. Molina will facilitate finding a new PCP or specialist as needed.

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

Molina will notify the Provider via fax of an individual Member's Advance Directives identified through Care Management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the

Medical Record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are State specific to meet State regulations.

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

Personal Attendant Services (PAS) Documentation Requirements

Provider agencies providing PAS for Molina members are responsible for maintaining service delivery records. The provider agency must maintain records of the services delivered to the member, including records relating to disagreements, suspensions and termination of services.

The provider agency must maintain a copy of the time sheet of the attendant's delivery of services to the member. Each time sheet must be a single document that contains:

- Name of the member
- Member's identification number
- Name of the attendant who provided services to the member
- Beginning and ending dates of service delivery period
- Tasks performed for the member
- Service Schedule
- Specific days and time the attendant worked
- Signature of the attendant and the date signed. An attendant who is unable to complete or sign the time sheet may designate another person to complete or sign the time sheet. If this occurs, the provider agency must document in writing: 1) the reason why the attendant was unable to complete or sign the time she; and, 2) the name of the person whom the attendant authorized to complete or sign the time sheet for the attendant
- Signature of the member or representative and the date signed. A member or representative who is unable to complete or sign the time she may designate another person to complete or sign the time sheet. The provider agency must document in writing: 1) the reason the member or representative was unable to complete or sign the time sheet; and 2) the name of the person whom the member or representative authorized to complete or sign the time sheet for the member.

Appropriate PAS Billing Practices

The provider agency agrees to submit correct and appropriate billings after services have been provided. The provider agency providing PAS is entitled to payment if all services were rendered in accordance to the member's plan of care and the member is not out of town/is not an inpatient of a hospital, intermediate care facility, skilled nursing facility, state hospital, state school, or intermediate care facility for persons with mental retardation or related conditions.

Electronic Visit Verification (EVV)

Providers of attendant care services, and any other services identified by HHSC must use an Electronic Visit Verification system to verify all care provided to members. Providers must use the system to electronically track and document the following information:

1. Provider's name;
2. Member's name receiving the service;
3. Service location;
4. Date and time the Provider begins and ends each service delivery visit; and
5. Any changes made to the EVV system data after the Provider has recorded time, including the name of the program Provider staff making the changes, the date the changes were made, and the reason for the changes.

Provider Compliance Requirements

All Providers using the EVV system maintain compliance with the following HHSC minimum standard requirements:

- The Provider must register their EVV vendor selection with Molina Healthcare, using the EVV vendor selection form.
- The Provider must enter Member information, Provider information, and service delivery schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual system.
- The Provider must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.
- Providers will ensure that all data elements required by HHSC are uploaded or entered into the EVV system completely, accurately, and in a timely manner.
- Providers must notify a Member's service coordinator if the Member refuses to allow home health attendants and nurses access to the Member's landline telephone to document when services begin and end.
- Providers must maintain service delivery visits verified in accordance with program requirements at least 90 percent per quarter. If 90% of the visits are not verified, Molina Healthcare reserves the right to impose liquidated damages and/or contract termination.
- Providers must ensure all data elements required by HHSC are uploaded or entered into the EVV system completely, accurately, and before billing for services delivered.
- Providers must ensure that the Provider's attendant uses the EVV system in a manner prescribed by HHSC to call-in when service delivery begins and call-out when service delivery is completed each time services subject to EVV are delivered to a Member.
- Providers will notify Molina Healthcare of any ongoing issues with EVV Vendors or unresolved issues with EVV systems.
- Equipment provided by an EVV contractor to a Provider, if applicable, must be returned in good condition. If equipment is lost, stolen, marked, altered or damaged by the Provider, the Provider may be required to pay the replacement cost of the equipment.
- Providers must notify Molina of any ongoing issues with EVV contractors or unresolved issues with EVV systems.

EVV Billing Requirements

- Providers must ensure that the Provider's attendant uses the EVV system in a manner prescribed by HHSC each time services subject to EVV are delivered to a Member. Attendants must call in when service delivery begins and call out when service delivery ends.
- Providers must ensure all data elements required by HHSC are uploaded or entered into the EVV system completely and accurately, before billing Molina Healthcare of Texas for services delivered. Failure to do so may result in a denial of a claim.
- Molina will only reimburse providers for claims for which there is a Matching Visit Verification (meaning the claim corresponds with the data from the EVV vendor). This means that providers should complete all visit verification, including visit maintenance with their EVV vendor prior to submitting a final claim to Molina.
- Visit Maintenance must be completed within 60 days of the date the services began.
- Molina will compare the claim to the verification data to ensure that the required data elements match. If there is any discrepancy, the claim will be denied.
- There is no change to Molina's requirements for prior authorization. If the visit verification and claim match, but there is not a valid authorization on file or the number of authorized units are exhausted, the claim will be denied. In the event additional services are required, providers must work with Molina's Health Care Services department to ensure additional authorizations are in place prior to providing the services.
- As always, providers can request claim reconsideration or appeal a claim decision; however, unverified visits will not be paid.

For more information on EVV Rights and Responsibilities, please reference HHSC's Form 1718, located at: <https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1718-electronic-visit-verification-evv-rights-responsibilities-managed-care-organization>.

Routine, Urgent and Emergent Services

Definitions

Routine Services means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent. All newly enrolled Members' Texas Health Steps visits should be conducted within 30 days of enrollment.

Severely disabled means that the Member's physical condition limits mobility and requires the client to be bed-confined at all times or unable to sit unassisted at all times or requires continuous life-support systems (including oxygen or IV infusion) or monitoring of unusual physical or chemical restraint.

Urgent Services means services for a health condition, including an Urgent Behavioral Health Situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical evaluation or treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within 24 hours, but which does not place the Member in immediate danger to themselves or others and the Member is able to cooperate with treatment.

Emergency Behavioral Health Condition- means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine: (1) requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or (2) which renders Members incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Services - means covered inpatient and outpatient services furnished by a provider who is qualified to furnish such services under the Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post- stabilization Care Services.

Emergency Prescription Supply - A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- "8" in "Prior Authorization Type Code" (Field 461-EU)
- "801" in "Prior Authorization Number Submitted (Field 462-EV)
- "3" in "Days Supply" (in the Claim segment of the billing transaction (Field 405-D5)
- The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber.

Call (855) 322-4080 for more information about the 72-hour emergency prescription supply policy.

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.

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Non-Emergency Transportation -When a client has a medical problem requiring treatment in another location and has no means of transportation, non-emergency service is covered. Non-emergency transports for a Medicaid client **must** be authorized prior to use.

TMHP guidelines are utilized during the review process. For specific information regarding your submission, please review TMHP for additional requirements.

A round-trip transport from the Member's home to a scheduled medical appointment is a covered service when the client meets the definition of severely disabled. All non-emergency ambulance transfers to a scheduled doctor's appointment require the doctor's name and address, the diagnosis, and treatment rendered at the time of visit.

Medicaid Emergency Dental Services:

Molina Healthcare is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- treatment of oral abscess of tooth or gum origin

Medicaid Non-emergency Dental Services:

Molina is **not responsible** for paying for routine dental services provided to Medicaid Members. These services are paid through Dental Managed Care Organizations.

Molina is **responsible** for paying for treatment and devices for craniofacial anomalies, and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members aged 6 through 35 months.

OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.

- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist Members with establishing a Main Dental Home and document Member's Main Dental Home choice in the Members' file.

CHIP Emergency Dental Services:

Molina Healthcare is responsible for emergency dental services provided to CHIP Members and CHIP Perinate Newborn Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- treatment of oral abscess of tooth or gum origin.

CHIP Non-emergency Dental Services:

Molina is **not responsible** for paying for routine dental services provided to CHIP and CHIP Perinate Members. These services are paid through Dental Managed Care Organizations. Molina is **responsible** for paying for treatment and devices for craniofacial anomalies.

How to Help a Member Find Dental Care

The Dental Plan Member ID card lists the name and phone number of a Member's Main Dental Home provider. The Member can contact the dental plan to select a different Main Dental Home provider at any time. If the Member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan's system, and the Member is mailed a new ID card within 5 business days.

If a Member does not have a dental plan assigned or is missing a card from a dental plan, the Member can contact the Medicaid/CHIP Enrollment Broker's toll-free telephone number at (800) 964-2777.

Chapter 10 – Cultural Competency

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 or have speech or cognitive/intellectual impairments. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at www.molinahealthcare.com, from your local Provider Services Representative and by calling Molina Provider Services at (855) 322-4080.

Nondiscrimination of Healthcare Service Delivery

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

Additionally, participating Providers or contracted medical groups/Independent Physician Associations (IPAs) may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care. Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they received assistance from a State Medicaid Program.

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

Members can also email the complaint to civil.rights@molinahealthcare.com.

Should you or a Molina Member need more information you can refer to the Health and Human Services website for more information: <https://www.federalregister.gov/d/2016-11458>

Cultural Competency

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

Provider and Community Training

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

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

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

Integrated Quality Improvement – Ensuring Access

Molina ensures Member access to language services such as oral interpretation, American Sign Language (ASL) and, written translation. Molina must also ensure access to programs, and aids and services that are congruent with cultural norms, support Members with disabilities, and assist Members with LEP.

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

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

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
 - Eligible individuals to identify significant culturally and linguistically diverse populations with plan's membership, and,
 -
 - Contracted Providers to assess gaps in network demographics
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
- 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.
- Determination of threshold languages annually and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS®/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.
- Comparison with selected measures such as those in Healthy People 2020

24 Hour Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Member Services toll free at (866) 449-6849/ (877) 319-6826 – CHIP RSA. If Member Services Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a language service.

Molina Providers must support access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina members interpreter services if the Members do not request them on their own. It is never permissible to ask a family member, friend or minor to interpret.

All eligible members who are Limited English Proficient (LEP) are entitled to receive interpreter services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, LRP, or limited hearing or sight are the financial responsibility of the Provider. Under no circumstance are Molina members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist Providers with locating these services if needed.

Documentation

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

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

Members who are Deaf or Hard of Hearing

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

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

Molina will provide face-to-face service delivery for ASL to support our members with hearing impairment. Requests should be made three (3) 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 twenty-four (24) hours/seven (7) days a week Nurse Advice Services for members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina Healthcare's Nurse Advice Line directly (English line (888) 275-8750) or (Spanish line at (866) 648-3537) or for assistance in other languages. The Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Reading/Grade Level Consideration (STAR, STAR+PLUS, MMP & CHIP)

Member materials are written at a 6th grade reading level or lower. The only exception to this is for medical or legal terminology.

Cultural Sensitivity (STAR, STAR+PLUS, MMP & CHIP)

Molina responds to the cultural, racial, and linguistic needs (including interpretive service as necessary) of the Medicaid population. Molina is backed by an organization that has focused on serving low-income families and individuals for the past 24 years, providing a wealth of experience in meeting the diverse needs of the Medicaid population. This experience provides Molina access to the experience, resources, and programs designed

to meet the unique healthcare needs of a culturally diverse membership. Molina has significant expertise in developing targeted health care programs for culturally diverse Members.

In demonstration of Molina's commitment to meeting the needs of a culturally diverse membership, cultural advisory committees have been established and are supported by one full-time cultural anthropologist who routinely advises Molina staff and committees about the differing needs.

It is Molina's intention to mail provider material that is culturally and linguistically appropriate for use by themselves and their patients. In addition, interpretation services will be available and in-service trainings and discussions will be encouraged on these topics.

All provider promotional, educational, training, or outreach material will include an inventory control number per the requirements of HHSC.

Chapter 11 - Complaints and Appeals

Medicaid Member Complaints and Appeals

Definitions

Complainant (1) means a Member, a treating provider or other individual designated to act on behalf of the Member who filed the Complaint. (2) A Provider who has filed a complaint.

Member Complaint is an expression of dissatisfaction expressed by a member, orally or in writing to Molina, about any matter related to the MCO other than a determination of medical necessity for a service as provided by 42 C.F.R §438.400. Possible subjects for Complaints include, but are not limited to, the quality of care of services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights. A complaint does not include a matter of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding or providing accurate information to the complainant.

Member Appeal is a formal process by which a Member or his/her representative requests a review of Molina's Action.

Member Inquiry is a request for information that is resolved promptly by providing the appropriate information; or a misunderstanding that is cleared up to the satisfaction of the Member.

Provider Complaint means an expression of dissatisfaction expressed by a provider, orally or in writing to Molina, about any matter related to Molina other than a determination of medical necessity for a service. A provider complaint does not include a matter of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding or providing accurate information to the provider's satisfaction.

Provider Inquiry is a request for information that is resolved promptly by providing the appropriate information; a misunderstanding that is cleared up to the satisfaction of the Provider.

Provider Claims Reconsideration is a dispute or request from a provider to review a claim denial or partial payment. Claim reconsideration includes, but is not limited to, timely filing, contractual payment issues etc.

Provider Claims Appeal is a written request for review of a claim denial or partial payment.

All claim appeals must be clearly identified as "Provider Claims Appeal" by written request and be accompanied with all necessary documentation which may include but is not limited to, medical records or if claim was previously reviewed through the reconsideration process.

Molina encourages providers to submit claims reconsideration prior to submitting a formal written claims appeal.

Medicaid Managed Care and Medicare-Medicaid Plan (MMP) Member Complaint Process

What should members do if they have a complaint? Who do they call?

If a member has a complaint, they can call Molina toll-free at (866) 449-6849 (Medicaid) or (866) 856-8699 (MMP) to tell us about their problem. A Molina Member Services Representative can help members file a complaint. Most of the time, Molina can help members right away, or at the most, within a few days.

Once a member has gone through the Molina complaint process, they can complain to the Health and Human Services Commission (HHSC) by calling toll-free (866) 566-8989. If the member would like to make their complaint in writing, they can send it to the following address:

Texas Health and Human Services Commission
Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

If a member can get on the Internet, they can send their complaint in an email to HPM_Complaints@hhsc.state.tx.us.

Can someone from Molina help members file a complaint?

Yes, we want to help members with the complaint process. When members have a complaint, they can call our Member Services Department. They will help members file the complaint. They will also be members' contact throughout the complaint process.

Member Services Toll Free: (866) 449-6849 (Medicaid) or (866) 856-8699 (MMP)

Members can send the complaint in writing to:

Medicaid	MMP
Molina Healthcare of Texas Attention: Member Inquiry Research and Resolution P.O. Box 165089 Irving, TX 75016	Molina Dual Options STAR+PLUS MMP Attn: Grievances and Appeals P.O. Box 22816 Long Beach, CA 90801-9977

How long will it take to process a complaint?

Member complaints will be processed within (30) calendar days or less, from the date Molina receives the complaint.

Requirements and timeframes for filing a Complaint:

- When Molina receives a complaint, Molina will send the member a letter within five (5) days telling them we have received their complaint.
- Molina will look into the complaint and decide the outcome. Molina will send the member a letter telling them the final outcome. Molina will not take more than thirty (30) calendar days to complete this process.
- Molina will keep track of all of the complaint information in a complaint log. If members need more information on their complaint, they can call Member Services.

Information on how to file a complaint with HHSC, once a member has gone through the Molina complaint process:

Once a member has gone through the Molina complaint process, they can complain to the Texas Health and Human Services Commission (HHSC) by calling toll free at (866) 566-8989. If they would like to make their request in writing, they can send it to the following address:

Texas Health and Human Services Commission
Health Plan Operations - H320
P.O. Box 85200
Austin, TX 78708-5200
Attn: Resolution Services

Medicaid and MMP Member Appeal Process

What can Providers do if Molina denies or limits my Member's request for a Covered Service?

Members can request an appeal for denial of payment for services in whole or in part.

Members can file an appeal with Molina anytime a service is denied or limited. Members will need to file the appeal within sixty (60) calendar days from the date on the letter telling them a service was denied or limited.

If a member is currently getting a service and that service is now being denied or limited, they will need to file their appeal within ten (10) calendar days from the day they get a letter telling them the service is being denied so they continue to receive the services they are now getting until their appeal is processed.

Please note that the Member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member.

How will members find out if services are denied?

Molina will send members a letter telling them a service has been denied.

What happens after a member files an appeal?

Once Molina has an appeal in writing, Molina will send the member a letter within five (5) business days telling them Molina has received their appeal and it is being worked on. The letter will also tell members that they can ask for a State Fair Hearing after first completing the internal appeals process. Molina will then review the information about the appeal. Molina may need to ask for more information from the member or the member's provider to help Molina make a decision. Members can review the information about their appeal at any time. Members can also appear in person, by telephone or tell Molina about their appeal in writing. Once the final decision is made, Molina will send the member and the member's provider a letter with the final decision. This process will not take more than then thirty (30) calendar days.

Members have the option to request an extension of up to fourteen (14) calendar days. Sometimes Molina may need more information. If this happens Molina may extend the appeals process by fourteen (14) days. If Molina extends the appeals process, we will let the member know by sending them a letter. This letter will let the member know the reason for the delay.

Who do members call?

Appeals are accepted orally and in writing. Members can call Molina Member Services and tell them they would like to file an appeal. Molina Member Services will help members file the appeal and give them updates during the appeal process.

Molina Member Services Toll Free: (866) 449-6849 (Medicaid) or (866) 856-8699 (MMP)

Members can also write their appeal and send it to:

Medicaid	MMP
<p>Molina Healthcare of Texas Attention: Member Inquiry Research and Resolution P.O. Box 165089 Irving, TX 75016</p>	<p>Molina Dual Options STAR+PLUS MMP Attn: Grievances and Appeals P.O. Box 22816 Long Beach, CA 90801-9977</p>

Can someone from Molina help members file an appeal?

Molina Member Services can help members file their appeal. Members should just ask for help when they call to file their appeal. **Members can also request a State Fair Hearing after completing Molina's appeal process.**

Expedited Molina Appeal

What is an expedited appeal?

An Expedited Appeal is when Molina must make a decision quickly based on the condition of the member's health and taking the time for a standard appeal could jeopardize the member's life or health.

How do members ask for an expedited appeal? Who can help Members file an Expedited Appeal?

Members can call Molina Member Services to file an expedited appeal. If assistance is required, Molina will help Members navigate the appeal process. **Expedited Appeal may be requested either orally or in writing.**

Do requests have to be in writing?

No, an Expedited Appeal may be requested either orally or in writing. Members can send a written expedited appeal to:

Medicaid	MMP
Molina Healthcare of Texas Attention: Member Inquiry Research and Resolution P.O. Box 165089 Irving, TX 75016	Molina Dual Options STAR+PLUS MMP Attn: Grievances and Appeals P.O. Box 22816 Long Beach, CA 90801-9977

Members can call Member Services Toll Free at (866) 449-6849 (Medicaid) or (866) 856-8699 (MMP).

What are the time frames for an expedited appeal?

Molina will make a decision on an expedited appeal within seventy-two (72) hours. An appeal can also be extended up to fourteen (14) calendar days, to gather more information, if it is in the member’s best interest to do so. Members will be notified if an extension is needed by phone and they will get a letter within two (2) business days.

If there is a risk to a member’s life, a decision will be made within twenty-four (24) hours from the time Molina gets the expedited appeal.

What happens if Molina denies the request for an expedited appeal?

Molina may make a decision that an appeal should not be expedited. If this decision is made, Molina will follow the standard appeal process. As soon as this is decided, Molina will try to call the member to let them know the standard appeal process will be followed. Molina will also send the member a letter within two (2) calendar days with this information.

State Fair Hearings and External Medical Reviews

Can a member ask for a State Fair Hearing?

If a Member, as a member of the health plan, disagrees with the health plan’s appeal decision, the Member has the right to ask for a fair hearing. The member may also request a fair hearing if Molina Healthcare does not make a decision on their appeal request within the required timeframe. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A provider may be the Member’s representative. The Member or the Member’s representative must ask for the fair hearing within 120 days of the date on the health plan’s appeal denial letter. If the Member does

not ask for the fair hearing within 120 days, the Member may lose his or her right to a fair hearing. To ask for a fair hearing, the Member or the Member's representative should either send a letter to the health plan at:

Medicaid	MMP
<p style="text-align: center;">Molina Healthcare of Texas Attention: Member Inquiry Research and Resolution P.O. Box 165089 Irving, TX 75016</p>	<p style="text-align: center;">Molina Dual Options STAR+PLUS MMP Attn: Grievances and Appeals P.O. Box 22816 Long Beach, CA 90801-9977</p>

Or call: (866) 449-6849 (Medicaid)/ (866) 856-8699 (MMP)

If the Member asks for a fair hearing within 10 days from the appeal decision, the Member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the Member does not request a fair hearing within 10 days from the date of the appeal decision, the service the health plan denied will be stopped.

If the Member asks for a fair hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most fair hearings are held by telephone. At that time, the Member or the Member's representative can tell why the Member needs the service the health plan denied.

HHSC will give the Member a final decision within 90 days from the date the Member asked for the hearing.

If the member loses the fair hearing, Molina may be able to recover the costs of providing the service or benefit to you while the appeal was pending.

External Medical Review

Can a member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision

letter and mail or fax it to Molina by using the address or fax number at the top of the form.;

- Call the MCO at (866) 449-6849;
- Email the MCO at TXMemberInquiryResearchAndResolution@MolinaHealthCare.Com, or;
- **Go in-person to a local HHSC office.**

If the Member asks for an External Medical Review within 10 days from the time the health plan mails the appeal decision, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing the Member can also request the Independent Review Organization to be present at the State Fair Hearing. The Member can make both of these requests by contacting the Member's MCO at (specify MCO information) or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, the State Fair Hearing decision is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Molina. To qualify for an emergency External Medical Review and emergency State Fair Hearing the Member must first complete Molina's internal appeals process.

Member Complaint Process (CHIP & CHIP Perinate)

What should members do if they have a complaint? Who do members call?

If a member has a complaint, they should call Molina toll-free at (866) 449-6849 (Dallas, Harris and Jefferson SA) or (877) 319-6826 (CHIP RSA). A Molina Member Services Representative can help the member file a complaint. Most of the time, we can help members right away or at the most within a few days.

Members can also write their complaint and send it to:

Molina Healthcare of Texas
P.O. Box 165089
Irving, TX 75016
Attention: Member Inquiry Research and Resolution
or

Texas Department of Insurance Consumer Protection (111-1A)

P.O. Box 149091
Austin, TX 78714-9091
E-mail: ConsumerProtection@tdi.state.tx.us

Main Number: (512) 463-6500
(800) 252-3439
Fax Number: (512) 475-1771
Information can also be accessed on the State website at:
www.tdi.state.tx.us/consumer/cpportal.html

If a member is not satisfied with the outcome, who else can they contact?

If a member is not satisfied with the answer to their complaint, they can also complain to the Texas Department of Insurance by calling toll-free to (800) 252-3439. If a member would like to make their request in writing, they can send it to:

Texas Department of Insurance Consumer Protection (111-1A)
P.O. Box 149091
Austin, TX 78714-9091

Can someone from Molina help members file a complaint?

Yes, we want to help members with the complaint process. When members have a complaint, they can call Member Services and ask for help with their complaint.

Member Services Toll Free Number (Dallas, Harris and Jefferson SA): (866) 449-6849
CHIP Rural Service Area (RSA) Toll Free Number: (877) 319-6826.

How long will it take to handle a member's complaint?

A complaint will be handled within thirty (30) calendar days from the date Molina receives it. It could take less than thirty (30) calendar days. Members will get a letter telling them how their complaint was resolved. This letter will explain the complete complaint and appeal process. It will also tell members about their appeal rights. If the complaint is for an emergency for inpatient hospital or on-going care, Molina will resolve the complaint within one (1) business day.

What do members need to do to file a complaint? How long do members have to file a complaint?

Members can file a complaint at any time. Members will receive a letter within five (5) calendar days telling them that their complaint was received. The complaint will be resolved within thirty (30) calendar days from the day Molina gets it.

Do members have the right to meet with a complaint appeal panel?

Yes, if a member is not happy with the results of their complaint, they can call Molina Member Services. Molina can help the member set up a meeting with the Complaint Appeal Panel. Molina's appeal panel includes a doctor, a Member and an employee of Molina. The providers will be familiar with the member's kind of complaint. Those on the panel will not have been involved in the member's case before. Molina will let the member know Molina received their appeal. A letter will let the member know the complete complaint and appeal process. This letter will also tell the about their appeal rights.

Members can call Member Services Toll Free at (866) 449-6849 or (877) 319-6826 (CHIP Rural Service Area (RSA) Toll Free Number).

Process to Appeal a CHIP Adverse Determination (CHIP & CHIP Perinate)

What can I do if the Molina denies or limits my patient's request for a covered service?

Members can file an appeal any time within one-hundred-eighty (180) days from the day they receive the letter telling them their doctor's request was denied or limited with Molina.

How will members be notified if the appeal is denied?

Molina will send the Member a letter. It will tell the Member if a the appeal was accepted or denied.

How long does the appeals process take?

Members will get a letter within five (5) business days. The letter will tell members that Molina received their appeal. The appeal will be handled within thirty (30) calendar days. The Calendar days start from the day Molina gets the appeal. Some appeals are for an emergency for inpatient hospital or on-going care. For emergency appeals Molina will resolve the appeal within one (1) business day. Molina will send the member a letter to let them know that their complaint has been handled. Molina will also send a copy of this letter to the member's provider.

When do members have the right to request an appeal?

Members can file an appeal any time within one-hundred-eighty (180) days after they have had a benefit denied. Members can also file one if a service was limited.

Do requests have to be in writing?

No, members can call Molina Member Services and ask for help with their appeal. Molina will accept appeals orally or in writing.

Member Services Toll Free:

Dallas, Harris and Jefferson SA Toll Free Number: (866) 449-6849

CHIP Rural Service Area (RSA) Toll Free Number: (877) 319-6826

Members can write the appeal on paper and send it to us. They can send their written appeal to:

Molina Healthcare of Texas
Attention: Member Inquiry Research and Resolution
P.O. Box 165089
Irving, TX 75016

Can someone from Molina help members file an appeal?

Yes, someone in Molina Member Services can help members file their appeal.

Expedited Appeal (CHIP & CHIP Perinate)

What is an expedited appeal?

An Expedited Appeal is when Molina must make a decision quickly based on the condition of a member's health and taking the time for a standard appeal could jeopardize a member's life or health.

How do members ask for an expedited appeal?

Members can call Molina Member Services and ask to file an expedited appeal.

Member Services Toll Free:

Dallas, Harris and Jefferson SA Toll Free Number: (866) 449-6849

CHIP Rural Service Area (RSA)-Toll Free Number: (877) 319-6826

Do requests have to be in writing?

No, members can call Molina Member Services and ask for help with their appeal. We will accept them orally or in writing.

Member Services Toll Free:

Dallas, Harris and Jefferson SA Toll Free Number: (866) 449-6849

CHIP Rural Service Area (RSA)-Toll Free Number: (877) 319-6826

Members can send their written appeal to:

Molina Healthcare of Texas
Attention: Member Inquiry Research and Resolution

P.O. Box 165089
Irving, TX 75016

How long will it take to handle an expedited appeal?

Molina will make a decision within one (1) business day. For emergency appeals, Molina will send a letter telling members that their complaint has been handled. Molina will also send the member's provider a letter telling him/her that the complaint has been resolved.

What happens if Molina denies the request for an expedited appeal?

Molina may make a decision that an appeal should not be expedited. If so, Molina will follow the regular appeal process. Once the process is complete, Molina will call the member to let the Member know the regular appeal process. Molina will tell the member what they can do next. Molina will send the member a letter within one (1) calendar day that tells the member of the denial. Molina will also send a copy of this letter to the member's provider.

This letter will have the complete complaint and appeal process and tell members about their appeal rights.

Who can help members in filing an expedited appeal?

Molina wants to help members with the expedited appeal process. Members can call Molina Member Services. When members call, they should tell Member Services they would like to file an expedited appeal. Member Services will know to work on it very quickly.

Dallas, Harris and Jefferson SA Toll Free Number: (866) 449-6849
CHIP Rural Service Area (RSA)-Toll Free Number: (877) 319-6826

Independent Review Organization (IRO) Process (CHIP & CHIP Perinate)

What is an Independent Review Organization (IRO)?

An IRO reviews the medical necessity of health care services. It is not part of Molina. It has no connection with our providers. Their decision is final.

How do members request an IRO review?

Members or their authorized representative can file a request for a review by an Independent Review Organization within four months after getting the final appeal decision from Molina. To make a request, the member or their authorized representative must complete the HHS-Administered Federal External Review Request form and submit it to MAXIMUS. There are three ways members can submit the form:

1. Online: <https://externalappeal.cms.gov> (under the "Request a Review Online" tab)
2. Fax: 1-888-866-6190
3. Mail: MAXIMUS Federal Services
3750 Monroe Avenue, Suite 750
Pittsford, NY 14534

If Members need help with the IRO process, they can call Molina Member Services.

Member Services Toll Free:

Dallas, Harris and Jefferson SA -Toll Free Number: (866) 449-6849
CHIP Rural Service Area (RSA)-Toll Free Number: (877) 319-6826

How long will the IRO review take?

Members must submit their request for an IRO external review within four (4) months of getting the final appeal decision from Molina. MAXIMUS will notify Molina immediately once the request is received. Molina will send all information MAXIMUS needs within five (5) days a receiving notice of the IRO request. MAXIMUS will make a decision about the External Review as soon as possible, but no later than 45 days after receipt of the request for standard requests. For expedited requests, MAXIMUS will make a decision within 72 hours.

Appeals of Medicare Benefits (MMP Only)

- Appeals of Medicare benefits are automatically sent to by Molina to the Medicare Independent Review Entity (IRE) if Molina upholds the initial denial.
- If the physician conducting the reconsideration upholds the original determination, the determination is forwarded to the Independent Review Organization (IRO), Maximus. Molina staff prepares the denial file and forwards to Maximus within the established timeframes and with the required information. If Maximus’ review upholds the adverse determination by Molina, enrollees are advised of their further appeal rights and choices. Details for these appeal processes are described in the Appeals Policy and Procedure.
- The third level of appeals for Medicare benefits are filed with the Office of Medicare Hearings and Appeals (OMHA).

Provider Complaints and Appeals

Provider Complaints

A provider has the right to file a complaint with Molina at any time. The provider also has the right to file a complaint directly with HHSC or TDI.

How to file a Medicaid Complaint (STAR and STAR+PLUS):

- A complaint can be oral or written:

MOLINA	HHSC
Call: (866) 449-6849	Call: 1-800-252-8263

Write to: Molina Healthcare of Texas Attention: Complaints and Appeals Dept. P.O. Box 165089	Write to: HHSC Po Box 85200 Austin, TX 78708 or HPM_Complaints@hhsc.state.tx.us
Fax to: (877) 319-6852	

- Complaints/Appeals can also be submitted online via the Provider Portal (<https://provider.molinahealthcare.com/Provider>)
 - Select “Claims Status Inquiry
 - Select Claim Type and search by Member Name/DOB, Member Number, Tracking Number, and Claim Status. After completing the required Search Criteria, select “Search.”
 - Select a Claim ID to see details.
 - Select Appeal Claim to appeal paid/denied claims
 - Fill out all the necessary information and select “Submit.”
- Documentation
 - All Complaint/Appeal Fax Cover Pages and emails to and from Molina regarding Provider complaints/appeals are stored and archived by Molina.
 - Telephone communication logs are tracked and stored in Molina’s Appeals and Grievances Database.

How to file a CHIP Complaint:

- A complaint can be oral or written:

MOLINA	TDI
Call: (866) 449-6849	Call: 1-800-252-3439
Write to: Molina Healthcare of Texas Attention: Complaints and Appeals Dept. P.O. Box 165089	Write to: TDI Consumer Protection P.O. Box 149091 Austin, Texas 78714-9091
Fax to: (877) 319-6852	

Complaint Timeframes:

- A provider can file a complaint anytime.
- When a complaint is received verbally, Molina will send an acknowledgement letter along with a one-page complaint form within five (5) business days.
- When Molina receives a written complaint from a provider, we will send an acknowledgement letter to the provider within five (5) business days.
- Complaints will be investigated, addressed, and the provider will be notified of the outcome, in writing, within thirty (30) calendar days from the date the complaint is received by Molina.

Provider Appeal Process

Appeal means the formal process by which a Provider requests a review of Molina’s Action.

Action means:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial in whole or in part of payment for services;
- The failure to provide services in a timely manner;
- The failure of Molina to act within the timeframes set forth in the contract; or
- For a resident of a rural area with only one HMO, the denial of a Medicaid Members’ request to obtain services outside of the Network.

How to file an appeal:

An appeal can be filed in writing or verbally.

Medicaid

MOLINA	
Call:	(866) 449-6849
Write to:	Molina Healthcare of Texas Attention: Complaints and Appeals Dept. P.O. Box 165089 Irving, TX 75016
Fax to:	(877) 319-6852

CHIP

MOLINA	TDI
Call: (866) 449-6849	Call: 1-800-252-3439
Write to: Molina Healthcare of Texas Attention: Complaints and Appeals Dept. P.O. Box 165089 Irving, TX	Write to: TDI Consumer Protection (111-1A) PO Box 149091 Austin, TX 78714-9091

Providers can also find more information about filing complaints and appeals on the Provider Portal: <https://provider.molinahealthcare.com/Provider>

- To submit a Complaint/Appeal via the Provider Portal, follow the steps below.

- Select “Claims Status Inquiry”
- Select “Claim Type” and search by Member Name/DOB, Member Number, Tracking Number, Claim Status. After completing the required Search Criteria, select “Search.”
- Select a Claim ID to see details.
- Select Appeal Claim to appeal paid/denied claims
- Fill out all the necessary information and select “Submit.”
- Documentation
 - All Complaint/Appeal Fax Cover Pages and emails to and from Molina regarding Provider complaints/appeals are stored and archived by Molina
 - Telephone communication logs are tracked and stored in Molina’s Appeals and Grievances Database.

Appeal Timeframes:

- The provider or practitioner is allowed one-hundred-twenty (**120**) days from the date of the initial denial notification to submit an appeal.
- Provider appeals should be resolved within thirty (30) calendar days of Molina’s receipt of the appeal.

Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- **The Explanation of Benefits (EOB) showing the original payment.** Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- **The EOB showing the recoupment and/or the plan’s “demand” letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- **Complete clean claim.** All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

Texas Health and Human Services Commission
 HHSC Claims Administrator Contract Management
 Mail Code – 91X
 P.O. Box 204077
 Austin, Texas 78720-4077

Recoupment Appeal Timeframe – EVV Only

EVV providers must submit appeals for claim recoupment within 60 days of the date on the recoupment notification.

Expedited Appeals (Medicaid)

Expedited Appeal (Medicaid) – Means an appeal to Molina in which the decision is required quickly based on the Member’s health status, and the amount of time necessary to participate in a standard appeal could jeopardize the Member’s life or health or ability to attain, maintain, or regain maximum function.

How to File an Expedited Appeal:

- A Member or Member’s representative has the right to file an expedited appeal with Molina. Molina’s expedited appeal process must be complete prior to requesting a fair hearing.
- Expedited appeals can be filed orally or in writing.

MOLINA	HHSC
Call: (866) 449-6849	Call: (800) 252-8263
Write to: Molina Healthcare of Texas Attention: Member Inquiry Research and Resolution P.O. Box 165089	Write to: HHSC Appeals Division, Fair Hearing Y-613 P.O. Box 149030 Austin, TX 78714

Expedited Appeal Process (CHIP)

1. A member, member’s authorized representative, or provider may submit an oral or written request for an expedited appeal to Molina. The expedited appeals request is forwarded to the Appeals Coordinator the same business day.
2. The Appeals Coordinator reviews the request and forwards the request for specialty review to ensure the provider reviewing the case has not previously reviewed the case and is of the same or similar specialty as typically manages the condition, procedure to treatment under review.
3. The time for resolution of an expedited appeal is based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received
4. If the appeal is denied, the resolution includes the following:
 - a. The clinical basis for the denial;
 - b. The specialty of the physician or other health care provider making the denial;
 and

- c. The appealing party's right to seek a review of the denial by an independent review organization under Subchapter I, and the procedures for obtaining that review.
5. If, upon review of the case, the request for an expedited appeal is denied, the following is implemented:
- a. The appeal is transferred to the timeframe for standard resolution, and
 - b. A reasonable effort is made to give the Member prompt oral notice of the denial and follow up within two (2) calendar days with a written notice.

Expedited Appeal Timeframes:

- Molina must acknowledge receipt of the Member’s request for an expedited appeal within one (1) business day.
- After Molina receives the request for an Expedited Appeal, it must notify the Member of the outcome of the Expedited Appeal within three (3) business days.
- Except Molina must complete the investigation and resolution of an Expedited Appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one (1) business day after receiving the Member’s request for Expedited Appeal is received.
- Except for an Expedited Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the Expedited Appeal may be extended up to fourteen (14) calendar days if the Member requests an extension or Molina shows (to the satisfaction of HHSC, upon HHSC’s request) that there is a need for additional information and how the delay is in the Member’s interest. If the timeframe is extended, Molina must give the Member written notice of the reason for delay if the Member had not requested the delay.

External Review by Independent Review Organization (CHIP)

What is an Independent Review Organization (IRO)?

The Member may be able to have an Independent Review Organization (IRO) review a decision by Molina to not pay for a treatment it considers medically unnecessary or inappropriate. The Member or Member’s representative must first appeal to Molina before requesting an IRO review.

How to Request an IRO Review

Members or their authorized representative can file a request for a review by an Independent Review Organization within four months after getting the final appeal decision from Molina. To make a request, the member or their authorized representative must complete the HHS-Administered Federal External Review Request form and submit it to MAXIMUS. There are three ways members can submit the form:

1. Online: <https://externalappeal.cms.gov> (under the “Request a Review Online” tab)
2. Fax: 1-888-866-6190

3. Mail: MAXIMUS Federal Services
3750 Monroe Avenue, Suite 750
Pittsford, NY 14534

IRO Review Timeframes

Members must submit their request for an IRO external review within four (4) months of getting the final appeal decision from Molina. MAXIMUS will notify Molina immediately once the request is received. Molina will send all information MAXIMUS needs within five (5) days a receiving notice of the IRO request. MAXIMUS will make a decision about the External Review as soon as possible, but no later than 45 days after receipt of the request for standard requests. For expedited requests, MAXIMUS will make a decision within 72 hours

Additional Resolution Options

Dissatisfied with STAR, STAR+ PLUS Complaint or Appeal Outcome?

Upon receipt of the **STAR/STAR+PLUS** complaint outcome, if the provider is still dissatisfied, the provider may contact HHSC for further resolution. For more information:

Call HHSC at: (512) 338-6569; Fax: (512) 794-6815; or
E-mail: provider.resolutions@hhsc.state.tx.us
Texas Health and Human Services Commission
Medical Appeals and Provider Resolution Division, Y-929
1100 West 49th Street
Austin, TX 78756-3172

Dissatisfied with CHIP Complaint or Appeal Outcome?

Upon receipt of the **CHIP** complaint outcome, if the provider is still dissatisfied, the provider may contact TDI for further resolution. For more information:

Call TDI at: (800) 232-3439; Fax (512) 475-1771; or
E-mail: ConsumerProtection@tdi.state.tx.us
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091

The Complaint and Appeal Coordinator will provide, upon request, a summary of the steps followed internally regarding the grievance to both the provider and HHSC.

Chapter 12 – Electronic Visit Verification (EVV)

This chapter establishes requirements for the Electronic Visit Verification (EVV) system that MCOs are required to use to verify certain services as identified by HHSC. This chapter defines the Medicaid services that require EVV and identifies the data elements that must be included to verify that the service occurred. Additionally, it sets out minimum requirements for Network Providers and HHSC-approved EVV contractors, for which MCOs must ensure compliance. These requirements are based on the authorities note below:

- Statutory and Regulatory Authority
 - Texas Government Code § 531.024172
 - General Appropriations Act, 83rd Leg., R.S., Ch. 1411, art. II, rider 51(b)(8), at II-100 (Health and Human Services Section, Health and Human Services Commission)
 - General Appropriations Act 82nd Leg., R.S., Ch. 1355, art II, rider 61(b)(8), at II-94 (Health and Human Services Section, Health and Human Services Commission)
- Informational Resources
 - 1 Tex. Admin. Code § 354.1177, “Electronic Visit Verification (EVV) System”
 - 40 Tex. Admin. Code §§ 68.101-68.103, “Electronic Visit Verification (EVV) System”

Definitions

Electronic Visit Verification (EVV) is the electronic verification and documentation of visit data, such as the date and time the provider begins and ends the delivery of services, the attendant, the recipient, and the location of the services provided. EVV is not applicable for CHIP or STAR members.

Member means a person who:

1. Is entitled to benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included in the STAR or STAR+PLUS Program, and is enrolled in Molina’s STAR or STAR+PLUS Program;
2. Is entitled to benefits under Title XIX of the Social Security Act and Medicaid, in in a Medicaid eligibility category as a voluntary participant in the STAR or STAR+PLUS Program, and is enrolled in Molina’s STAR or STAR+PLUS Program;
3. Has met the CHIP eligibility criteria and is enrolled in Molina’s CHIP Program; or
4. Has met CHIP Perinatal Program eligibility criteria and is enrolled in Molina’s CHIP Perinatal Program.

Non-preferred Reason Code means changes made in an EVV system (sometimes referred to as “visit maintenance”) to document a situation in which a provider did not provide or document services as required by HHSC. Providers can find more information

on Reason Codes later in this chapter or by visiting <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/evv-reason-codes> .

Preferred Reason Code means changes made in an EEV system (sometimes referred to as “visit maintenance”) to document a situation where services were provided and documented as required by HHSC. Providers can find more information on Reason Codes later in this chapter or by visiting <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/evv-reason-codes>

Provider means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors that has a contract with Molina for delivery of Covered Services to Molina’s members.

Visit Maintenance means the process by which providers can make adjustments in an EVV system to electronically document service delivery visit information as required by HHSC.

What is EVV?

- Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends.
- EVV is a method by which a person, including but not limited to a personal care attendant, who enters a STAR+PLUS, STAR Kids, Medicare-Medicaid Plan (MMP), or Community First Choice Member’s home to provide a service will document their arrival time, services and departure time using a telephonic application system. This visit information will be recorded and used as an electronic version of a paper time sheet for an attendant and to support claims to the MCO for targeted EVV services.

Do providers have a choice of EVV vendors?

- Provider selection of EVV vendor
 - During the contracting and credentialing process with an MCO, a copy of the Provider Electronic Visit Verification Vendor System Selection form should be provided in the application packet. A provider is required to use a HHSC-approved EVV vendor as listed on the selection form and select “Initial Selection.” Forms are located at MolinaHealthcare.com
- Provider EVV default process for non-selection
 - Mandated providers that do not make an EVV vendor selection or who do not implement use of their selected vendor, are subject to contract actions and/or will be defaulted to a select vendor by HHSC. The provider will receive a default letter detailing out the vendor that they have been defaulted to and when they are required to be implemented with the vendor.
- When can a provider change EVV vendors?
 - A provider may change EVV vendors 120 days after the submission date of the change request.

- o A provider may change EVV vendors only twice in the life of their contract with the MCO.
- o A provider will submit an updated copy of the Provider Electronic Visit Verification Vendor System Selection form and select “Vendor Change” when requesting a change to another EVV Vendor.

Can a provider elect not to use EVV?

All Medicaid-enrolled service providers (provider agents) who provide STAR+PLUS, STAR Kids, Medicaid and Medicare Program (MMP) and CFC services that are subject to EVV are required to use a HHSC approved EVV system to record on-site visitation with the individual/member. Those services include:

- Personal assistance services (PAS)
- In-Home Respite
- Community First Choice – PAS/Habilitation

Is EVV required for CDS employers?

No. CDS Employers have the option to choose from the following 3 options:

- a. **Phone and Computer (Full Participation):** The telephone portion of EVV will be used by Computer Directed Services (CDS) Employee(s) and you will use the computer portion of the system to perform visit maintenance.
- b. **Phone Only (Partial Portion):** This option is available to CDS Employers who can participate in EVV but may need some assistance from the FMSA with visit maintenance. You will use a paper time sheet will be used to document service delivery. Your CDS Employee will call-in when they start work and call-out with the end work. Your FMSA will perform visit maintenance to make the EVV system match your paper time sheet.
- c. **No EVV Participation:** If you do not have access to a computer, assistive devices, or other supports, or does not feel you can fully participate in EVV, you may choose to use a paper time sheet to document service delivery.

How do providers with assistive technology (ADA) need to use EVV?

If you use assistive technology and need to discuss accommodations related to the EVV system or materials, please contact the HHSC-approved EVV vendor.

DataLogic (Vesta) Software, Inc.

Contact:	Email:	Phone:
Sales & Training	info@vestaevv.com	(888) 880-2400
Tech Support	support@vesta.net	
Website: www.vestaevv.com		

EVV use of small alternative device (SAD) process and required SAD forms

The SAD process can be found at:

- <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/training-materials-resources>

- Forms can be found here: MolinaHealthcare.com
- Where do I submit the SAD agreement/order form?
 - The form is submitted to the provider selected EVV vendor
 - DataLogic – email form to: tokens@vestaevv.vom or send secure efax to 956-290-8728
- Equipment provided by an EVV contractor to a Provider, if applicable, must be returned in good condition.

What is the HHSC Compliance Plan?

- The HHSC Compliance Plan is a set of requirements that establish a standard for EVV usage that must be adhered to by Provider Agencies under the HHSC EVV initiative.
- Provider Agencies must achieve and maintain an HHSC EVV Initiative Provider Compliance Score of at least 90 percent per Review Period. Reason Codes must be used each time a change is made to an EVV visit record in the EVV System.

EVV Compliance

All providers providing the mandated services must use the EVV system and must maintain compliance with the following requirements:

- The Provider must enter Member information, Provider information, and service schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual process. The provider agency must ensure that all required data elements, as determined by HHSC, are uploaded or entered into the EVV system completely and accurately upon entry, or they will be locked out from the visit maintenance function of the EVV system.
- The provider must ensure that attendants providing the services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.
- The Provider Agency must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
- The provider agency must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
- Providers should notify the appropriate MCO, or HHSC, within 48 hours of any ongoing issues with EVV vendors or issues with EVV systems.
- Provider Agencies must complete any and all required visit maintenance in the EVV system within 60 days of the visit (date of service). Visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. Provider Agencies must submit claims in accordance with their contacted entity claim submission policy. No visit maintenance will be allowed more than 60 days after the date of service and before claims submission, unless an exception is granted on a case-by-case basis.
- Provider agencies must use the reason code that most accurately explains why a change was made to a visit record in the EVV System. The MCOs, will review reason code use by their contracted provider agencies to ensure that preferred reason codes are not misused.
- If it is determined that a provider agency has misused preferred reason codes, the provider agency HHSC EVV Initiative Provider Compliance Plan Score may be

negatively impacted, and the provider agency may be subject to the assessment of liquidated damages, imposition of contract actions, implementation of the corrective action plan process, and/or referral for a fraud, waste, and abuse investigation.

- Provider agencies must ensure that claims for services are supported by service delivery records that have been verified by the provider agency and fully documented in an EVV System
- Claims are subject to recoupment if they are submitted before all of the required visit maintenance has been completed in the EVV System.
- Claims that are not supported by the EVV system will be subject to denial or recoupment.
 - With the exception of HHSC-identified Displaced CM2000 providers, all provider agencies must use the EVV system as the system of record by September 1, 2015.
 - HHSC-identified Displaced CM 2000 providers must use the EVV system as the system of record by February 1, 2015.
- Adherence to the Provider Compliance Plan
 - The MCO Compliance Plan: www.MolinaHealthcare.com
- Any Corrective action plan required by an MCO is required to be submitted by the Network Provider to the MCO within 10 calendar days of receipt of request.
- MCO Provider Agencies may be subject to liquidated damages and termination from the MCO network for failure to submit a requested corrective action plan in a timely manner.

EVV Complaint Process

A complaint can be filed verbally or in writing.

MOLINA
Call: (866) 449-6849
Write to: Molina Healthcare of Texas Attention: Complaints and Appeals Dept. P.O. Box 165089 Irving, TX

EVV Refusal Process

Providers cannot refuse to participate in EVV. They must participate in in the program as long as they have EVV services.

Will there be a cost to the provider for access and use of the selected EVV vendor system? No, there is no cost to the provider for access and use of the selected EVV Vendor System.

Providers of Home Health Service Responsibilities

Providers can access HHSC's Provider Compliance Plan (excluding Consumer-Directed Services (CDS) at <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/provider-compliance-plans>

Non-CDS EVV providers must adhere to the Provider Compliance Plan found at MolinaHealthcare.com or by contacting your MCO at (855) 322-4080 or MHTEVV@MolinaHealthcare.com for the most current version.

Use of Reason Codes

A reason code is a standardized HHSC-approved three-digit number and description used during visit maintenance to explain the specific reason a change was made to an EVV visit record. Providers must associate the **most appropriate** reason code with each change made in visit maintenance and enter any required free text in the comment section. A single visit may have more than one reason code associated with it. Once a reason code is saved to a visit, it cannot be deleted. The most current reason code listing can be found at:

<https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/hhsc-reason-code.pdf>

Will training be offered to providers?

Yes, training will be offered for all providers, including CDS Providers. The EVV Training Schedule can be found on our website, MolinaHealthcare.com.

Will claim payment be affected by the use of EVV?

Yes, providers must adhere to EVV guidelines in Provider Compliance Plan when submitting a claim.

- Molina will receive transaction files daily. These files will be compared to submitted claims to locate a "match." Claims with a matching transaction will process through the claims system.
- Claims without a "match" will be held for the 60-day visit maintenance period and checked daily against the vendor transaction files. After 60 days, they will be denied if no match is found.

Claims must be submitted within 95 calendar days of the EVV visit.

What if I need assistance?

For assistance or questions regarding EVV, please email MHTEVV@MolinaHealthcare.com or call Provider Services at (855) 322-4080.

MCO Contracting for Electronic Visit Verification

HHSC will select and approve contractors for participation in the EVV program. Further, HHSC will negotiate maximum standard one-time EVV implementation costs and EVV transaction costs with the approved contractors. Molina must contract with all EVV contractors approved by HHSC, and the contracts between Molina and the HHSC-approved EVV contractors must include the standard rates negotiated by HHSC. Additionally, Molina must provide oversight and compliance of all EVV contractors.

MCO Member Education Requirements

- The MCO must educate its Members about EVV and the Members' responsibility to allow a Provider access to a landline telephone in a Member's home to record the beginning and end of services.
- If a Member refuses to allow home health attendants and nurses access to the Member's landline telephone, the Service Coordinator must discuss the EVV requirements with the Member to ensure he or she fully understands the requirement. An alternate device can be placed in the Member's home that the home health attendant or nurse may use in place of a landline telephone. If the Member still refuses to cooperate, the MCO must work with HHSC to find an appropriate solution.

MCO EVV Reporting Requirements

- The MCO must require EVV contractors to complete and submit a monthly EVV Summary Report using the template and instructions in Uniform Managed Care Manual Chapter 8.8. The MCO must submit the monthly EVV Summary Reports it receives from each EVV contractor to HHSC 30 days after the close of the reporting quarter.
- On the first day of each month, the MCO must submit an EVV Contractor Compliance Report to HHSC detailing any action taken by the MCO in the previous month for noncompliance by any EVV contractor, including a list of corrective action plans submitted by an EVV contractor and the status of each plan and any liquidated damages assessed against an EVV contractor.
- In addition to the monthly EVV Summary Report and the monthly EVV Contractor Compliance Report, HHSC reserves the right to request ad-hoc reports from the MCO for EVV information not included in the monthly EVV Summary Report, as needed.
- The MCO will send EVV data to HHSC consistent with requirements in the applicable Joint Interface Plan (JIP).

Chapter 13 - Quality Improvement

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality Department at (855) 322-4080.

The address for mail requests is:
Molina Healthcare of Texas
Attn: Quality Department
5605 N. MacArthur Blvd., Suite 400
Irving, TX 75038

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 Process that complies with regulatory and accreditation guidelines. The Quality Improvement Program provides structure and outlines specific activities designed to improve care, service and health of our members. Molina does not delegate Quality Improvement activities to Medical Groups/IPAs. However, Molina requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care. In addition, 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; and
- Allow access to Molina Quality personnel for site and medical record review processes.

Quality Improvement Activities and Programs

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

Program Components

The QIP provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The QIP program utilizes a variety of studies, quality indicators and routine performance monitors that provide an ongoing mechanism for quality improvement. Various performance measures are utilized to evaluate the QIP program.

These performance measures include:

- Topic-specific focused reviews based on established standards, parameters, or guidelines;
- Comprehensive medical record and office review of all PCP, OB/GYN and high-volume specialist sites at least every 24 months;
- Preventive health/health status reviews (immunization, childhood, adolescent, adult, well elderly, obstetric);
- Population-based studies;
- HEDIS measures;
- Internal quality of care measures;
- Disease Management Program studies;
- Clinical and/or service audits as mandated by HHSC/CMS
- Member complaints and grievances;
- Annual member satisfaction survey (CAHPS)
- Access indicators;
- Annual provider satisfaction surveys;
- Continuity and coordination of care monitoring; and
- Credentialing and re-credentialing of providers.

Health Management

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

Care Management

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

Program Compliance with Regulatory and Accrediting Bodies

Molina's comprehensive Quality Management (QM) Program is developed and administered to be in compliance with the standards established by the National Committee for Quality Assurance (NCQA), Texas Health and Human Services Commission and the Centers for Medicare & Medicaid Services (CMS).

Annually Molina completes Healthcare Effectiveness Data and Information Set (HEDIS) data collection and tabulation. HEDIS is administered by the National Committee for

Quality Assurance (NCQA) and is a standardized and comprehensive set of measures and reports that show how managed care plans compare regarding the care provided to members. Approximately 80 measures are reported to evaluate the effectiveness of services offered, utilization of services

and member satisfaction. Some examples of these measures include use, accessibility, and availability of services and how the plan manages health problems such as heart disease, cancer, diabetes, asthma and smoking. The data is an important part of measuring the quality of care provided for our members.

Focus Studies, Utilization Management and Clinical Practice Guidelines

The QIP establishes and maintains focused review and clinical study processes to monitor, review, measure, track/trend and provide for the development and implementation of corrective action plans for specifically identified practitioners, processes, illnesses, diagnostic treatments, meaningful clinical issues.

The Utilization Management Department submits quarterly reports to the Medical Advisory Committee, a subcommittee of the Quality Improvement Committee. The MAC review utilizes trends in the areas of emergency room, NICU, inpatient, outpatient and top diagnosis to identify opportunities for improvement.

Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority. CPGs are reviewed annually and are updated as new recommendations are published. Molina CPGs include the following:

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

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through Provider newsletters, electronic provider bulletins and other media and are available on the Molina website. Individual Providers or Members may request copies from the local Molina Quality Department at (855) 322-4080.

Molina also submits quarterly reports that include the number of critical incident and abuse report for STAR+PLUS members receiving LTSS and the number of Molina service coordinators receiving CDS training.

Using Performance Data

Molina Healthcare monitors and evaluates the quality of care and services provided to members/enrollees through the following mechanisms:

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

The most recent results of these surveys can be obtained from the QI Department by calling (855) 322-4080.

Contracted Providers and Facilities must allow Molina Healthcare 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.

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.

Patient Safety Program (MMP Only)

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

Quality of Care

Molina has established a systematic process to identify, investigate, review and report any Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable), and/or service issues affecting Member care. Molina will research, resolve, track and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error

in medical care that is clearly identifiable, preventable and/or 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 patient

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

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors Member complaints and appeal/grievances for all office sites to determine the need for an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical Accessibility
- Physical Appearance
- Adequacy of Waiting and Examining Room space

Physical Accessibility

Molina evaluates office sites 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, and ease of access for patients with physical disabilities.

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

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

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 for flat entryway, and the restroom is accessible with a bathroom grab bar.

- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes pocket masks and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Blood-borne pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Records rooms and/or file cabinets are preferably locked.
- A CLIA waivers displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired ample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

EPSDT Service to Members/Enrollees Under Twenty-One (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 Members/Enrollees under twenty-one (21) years of age are timely according to required preventive guidelines. All Members/Enrollees under twenty-one (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 department is also available to perform Provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

Well Child/Adolescent Visits

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

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height and weight and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations.
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.

- Periodic developmental and behavioral screening.
- Vision and hearing tests.
- Dental assessment and services.
- Health education (anticipatory guidance including child development, healthy lifestyles, accident and disease prevention).

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

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

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Within thirty (30) calendar days of the review, a copy of the review report and a letter will be sent to the medical group notifying them of their results. Performance below Molina's standards may result in a Corrective Action Plan (CAP) with a request the Provider submit a written corrective action plan to Molina within thirty (30) calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's 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.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Perinatal/Prenatal Care
- Care for children up to twenty-four (24) months old
- Care for children two to nineteen (2-19) years old
- Care for adults twenty to sixty-four (20-64) years old
- Care for adults sixty-five (65) years and older
- Immunization schedules for children and adolescents
- Immunization schedules for adults

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to Providers at www.MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistics 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)
- Behavioral Health Survey (Medicaid Only)
- Health Outcomes Survey (MMP Only)
- 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 staff at (855) 322-4080 or by visiting our website at www.MolinaHealthcare.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the NCQA® HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

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

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

Consumer Assessment of Healthcare Providers and Systems® (CAHPS)

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

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

Behavioral Health Survey (Medicaid Only)

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

Medicare Health Outcomes Survey (HOS) (MMP Only)

The HOS measures Medicare Members' physical and mental health status over a two (2) year period and categorizes the two (2) year change score as better, same or worse than expected. The goal of the HOS is to gather valid, reliable, clinically meaningful data that can be used to target quality improvement activities and resources, monitor health plan performance and reward top performing health plans. Additionally, the HOS is used to inform beneficiaries of their health care choices, advance the science of functional health outcomes measurement, and for quality improvement interventions and strategies.

Provider Satisfaction Survey

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

Effectiveness of Quality Improvements Initiatives

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

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

What Can Providers Do?

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

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit Molina's website and click on Providers. There is a variety of resources, including:

- HEDIS® CPT/CMS-approved diagnostic and procedural code sheets
- A current list of HEDIS® and CAHPS® Star Ratings measures.

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

Merit-based Incentive Payment System (MIPS)

Under the Medicare Access and CHIP Reauthorization Act (MACRA), CMS implemented the Quality Payment Program Merit-based Incentive Payment System (MIPS). This is a quality payment program that eligible providers under original Medicare will participate in and does not impact how Medicare Advantage and MMP plans are required to pay. Due to this being a quality program, providers will not receive a bonus or a withhold for the Quality Payment Program Merit-based Incentive Payment System (MIPS), unless it is specifically in the agreement you have with Molina. Please contact your Provider Services Representative for other quality programs Molina offers.

Medicare Quality Partner Program (MMP Only)

Molina Healthcare of Texas, Inc.'s Medicare Quality Partner Program is a bonus program that recognizes providers contracted with Molina Healthcare of Texas, Inc. who have consistently demonstrated sound clinical care practice(s), accurate evaluation and recording of chronic conditions, and quality-focused provision or arrangement of Covered Services on behalf of Molina Healthcare of Texas, Inc.'s Medicare members.

Please contact your local Provider Service Representatives for additional information, which will include the terms of the Quality Partner Program that the provider is required to follow if participation is agreed to by Molina Healthcare of Texas, Inc. and the provider.

Chapter 14 - Delegation

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

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

Delegation Criteria

Sanction Monitoring

All sub-contractors of Molina are required to show proof of processes to screen staff and employees at all levels against Federal 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 which meet Molina criteria. To be delegated for sanction monitoring functions, Providers must:

- Pass Molina's sanction monitoring pre-assessment, which is based on CMS standards;
- Demonstrate the employees and staff are screened against Office of Inspector General (OIG) and System for Award Management (SAM) sanction lists prior to hire dates, and monthly thereafter.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for sanction monitoring delegates.
- Submit timely and complete Sanction Monitoring delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.
- When staff or employees are identified as having a positive sanction, provide Molina with notification according to Contractual Agreements of the findings and action(s) being taken to ensure sanctioned staff is not provider services to Molina members.

Credentialing

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

- Pass Molina's credentialing pre-assessment, which is based on NCQA© credentialing standards.

- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of practitioners included in delegation.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against OIG and SAM exclusion lists a minimum of every thirty days.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for credentialing delegates.
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable federal and state Laws.
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members.

Note: If the Provider is an NCQA Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modifications to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA® accredited or certified in Credentialing functions or demonstrate and ability to meet all Health Plan, NCQA, and State and Federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be completed on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, Credentialing Committee Minutes, Ongoing Monitoring documentation, and a process to implement corrective action if issues of non-compliance are identified.

An entity may request Credentialing delegation from Molina through Molina's Delegation Oversight Manager or through their Contract Manager. Molina will ask the potential delegate to submit a Credentialing Pre-Delegation survey, policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Credentialing responsibilities is based on the entity's ability to meet Molina, State and Federal requirements for delegation.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports determined by the function(s) delegated to the identified Molina Delegation Oversight Staff within the timeline indicated by the Health Plan. For a copy of Molina's current delegation reporting requirements, please contact your Molina Contract Manager.

CMS Preclusion List

All subcontractors delegated for Credentialing and/or Claims Administration must review their Provider network against the CMS Preclusion list. The CMS Preclusion list will be

provided to the subcontractor on a monthly basis by Molina. Within five (5) business days of receipt, the subcontractor must review the list and identify any Providers with a new preclusion since the last publication date. Within fifteen (15) calendar days of receipt of the list, the subcontractor must notify Molina of any identified Provider(s), including a report of all Molina Claims paid to the Provider in the previous twelve (12) months. Depending on delegated expectations, subcontractors may also be responsible for sending the necessary Member notification at least sixty (60) calendar days prior to the Preclusion effective date, informing the Member of the need to select a new Provider.

Note: Member notification responsibilities depend on the functions delegated and the services provided. Not all subcontractors are responsible for this piece, and in some cases, are required to send the appropriate information to Molina so that Molina can notify impacted Members. If there are questions about subcontractor responsibilities related to Member notification of precluded Providers, please contact your Molina Delegation Oversight contact.

Chapter 15 - Behavioral Health

(STAR, STAR+PLUS, MMP & CHIP)

Molina Healthcare recognizes that the access to high quality behavioral healthcare is critical to the overall health and wellbeing of their members.

What is Behavioral Health?

Behavioral health services are provided for the treatment of mental disorders, emotional disorders, and chemical dependency disorders. Molina offers a behavioral health program that integrates management of behavioral health care with medical care needs for children and adults.

Molina behavioral health services are offered through a large and comprehensive network of behavioral health (BH) providers, including but not limited to, hospitals, chemical dependency treatment facilities licensed by the Department of State Health Services and practitioners of the healing arts, located within each service area. In order to better assist these valued BH providers, Molina Healthcare now manages behavioral health services with a behavioral health care management team. This team is comprised of licensed behavioral health professionals who will assist the behavioral health provider network, as well as medical care providers and other community support programs to communicate, coordinate and meet the integrated care needs of our members.

Dallas Service Area

Effective January 1, 2017, NorthStar will be discontinued and MCOs in the Dallas Service Area will be responsible for Medicaid Behavioral Health Services consistent with all over Service Areas.

Call Molina at (866) 449-6849 for behavioral health questions. Members can also call the 24-hour Behavioral Health Crisis Line at (800) 818-5837 in crisis situations. This number is on the back of member ID cards.

Behavioral Health Care Management Team

The Molina Healthcare Behavioral Health Care Management Team provides co-location of licensed behavioral health professionals with the medical care management, care coordination and general utilization management teams. This cross-disciplinary team consists of dedicated professionals (e.g., psychiatrists, nurses, clinical social workers, licensed professional counselors) who are on hand to work in collaboration with the medical care managers to assist with appropriate coordination between behavioral health and physical health services.

Behavioral Health for STAR, STAR+PLUS, MMP and CHIP/CHIP Perinate Newborn Members

Behavioral Health Crisis Hotline

Molina Healthcare maintains a 24 hour/7 days a week toll-free Behavioral Health Crisis Hotline. Crisis line services are provided during normal business hours, as well as after business hours, by the Molina Healthcare.

English: (800) 818-5837 (Translation services available)

Nurse Advice Line (NAL)

Molina Healthcare has a toll-free multi-lingual nurse advice telephone line available to Members and Providers on a 24-hour basis, 7 days per week. Staff on this advice line take calls from Members and perform triage services to help determine the appropriate setting from which they should obtain necessary care. In all instances, the staff on the advice line coordinates all care with the Member's primary care physician.

The nurse advice line is accessed through a toll-free telephone number, as well as through information in the Member handbook and other written material. The Nurse Advice Line phone numbers are:

English: (888) 275-8750

Spanish: (866) 648-3537

Coordination, Self-Referral, PCP Referral

The member may self-refer for behavioral health services to any in-network Behavioral Health provider. However, Primary Care Providers participating in the Texas Medicaid STAR, STAR+PLUS, MMP and CHIP Programs are responsible for coordinating Members' physical and behavioral health care, including making referrals to BH providers when necessary.

PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. PCPs may utilize Molina's Behavioral Health toolkit when working with patients. This toolkit is located on Molina's Provider Portal.

Behavioral health service providers must refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. Behavioral health providers must send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PCP, with the member's or member's legal guardian's consent.

The Molina Healthcare Behavioral Healthcare Management Team will assist in the cross communication of patient information, referral needs, treatment progress, etc. between

Behavioral Health providers and the PCP. You can call them at (866) 449-6849/ (877) 319-6826 (CHIP RSA).

Member Access to Behavioral Health Services

Members may access services with any participating provider within the Molina Healthcare behavioral health care network by contacting Member Services at (866) 449-6849/ (877) 319-6826 (CHIP RSA). Case Managers are available to answer questions regarding treatment options, medications, and behavioral health issues twenty-four (24) hours per day, seven (7) days per week.

Covered Behavioral Health Services

A wide range of behavioral health and chemical dependency services are available although specific benefits and benefit limits vary according to coverage group and member age (e.g., CHIP, CHIP Perinate, STAR or STAR+PLUS). Generally, the following behavioral health services may be available:

- Inpatient mental health services (including authorized inpatient Hospital services provided in Freestanding Psychiatric Facilities for children in STAR and STAR+PLUS, and for adults in STAR+PLUS)
- Attention Deficit Hyperactivity Disorder (ADHD)
 - ADHD covered services eligible for reimbursement include: outpatient counseling services for the management of ADHD symptoms to include coping skills, psychoeducation, etc. Medication management with psychiatric prescribers is also covered.
 - Primary care providers should have a strategy for diagnosing and long-term management of ADHD. Providers can discuss the efficacy of using medication to manage an ADHD diagnosis with their patients. Follow up appointments should be made at least monthly until the child's symptoms have been stabilized. Once a child is stable, AAP guidelines recommend an office visit every 3 to 6 months to assess learning and behavior.
- Substance Use Disorder Treatment (alcohol opioid use, etc.), including assessment, detoxification, residential treatment, outpatient services and medication therapy
- Outpatient mental health services
- Counseling services
- Psychiatry services
- Mental Health Rehabilitative Services

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment services for Members who are 10 years of age and older and who have alcohol or substance use disorders or are at risk of developing such disorders. SPIRT is used for intervention directed to individual members and not for group intervention.

SBIRT services can be provided by physicians, registered nurses, advanced practice nurses, physician assistants, psychologists, licensed clinical social workers, licensed professional counselors, certified nurse midwives, outpatient hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs). Non-licensed providers may deliver SBIRT under the supervision of a licensed provider if such supervision is within the

scope of practice for that licensed provider. The same SBIRT training requirements apply to non-licensed providers.

Members may have a maximum of two screening-only sessions per rolling year, and up to four combined screening and brief intervention sessions per rolling year. Providers must refer members to treatment if the screening results show severe risk of alcohol or substance use.

Screening

Screening members for problems related to alcohol or substance use identifies the member's level of risk and determines the appropriate level of intervention needed. Providers must explain the screening results to the member and be prepared to deliver necessary brief intervention services or refer to another provider for the services. Screening must be conducted using a standardized screening tool. Standardized tools that may be used include, but are not limited to, the following:

- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- Drug Abuse Screening Test (DAST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut-down, Annoyed, Guilty, Eye-opener (CAGE) questionnaire
- Care, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) questionnaire
- Binge drinking questionnaire

Results obtained through blood alcohol content (BAC) or through toxicology screening may also be used to screen for alcohol or substance use risk.

Brief Intervention

Brief intervention is performed following a positive screening or finding at least a mild to moderate risk for alcohol or substance use. During the session, brief intervention involves motivation interviewing techniques (such as Brief Negotiated Interview) that is focused in raising the member's awareness of his or her alcohol or substance use and its consequences. The session is also focused on motivating the member toward behavioral change. Subsequent screening and brief intervention sessions within allowable annual limitations may be indicated to assess for behavioral change and further explore a member's readiness to make behavioral changes related to their alcohol or substance use.

Referral to Treatment

If a provider determines that a member is in need of more extensive treatment or has a severe risk for alcohol or substance use, the member must be referred to an appropriate substance use treatment provider. Referral to more extensive treatment is a proactive process that facilitates access to care for members who require a more extensive level of service than SBIRT providers. Referral is an essential component of the SBIRT intervention because it ensures that all clients who are screened have access to the appropriate level of care.

Court Ordered Commitments

Up to the annual limit, Molina will provide inpatient psychiatric services to Members who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities. Molina will not deny, reduce or controvert the medical necessity of any inpatient psychiatric services provided pursuant to a court-ordered commitment. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Member who has been ordered to receive treatment under the provisions of Chapters 573 or 574 of the Texas Health and Safety Code can only appeal the commitment through the court system and cannot appeal the commitment through Molina's complaint and appeals process. Molina is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code.

\$200,000 annual limit on inpatient services does not apply for adult STAR and STAR+PLUS members.

Coordination with the Local Mental Health Authority

Molina will coordinate with the Local Mental Health Authority and state psychiatric facilities regarding admission and discharge planning and treatment objectives, and projected length of stay for members committed by a court of law to the state psychiatric facility.

Medical Records and Referral Documentation

When reporting to HHSC, Behavioral Health providers must use the most current DSM multi-axial classifications in effect at the time of service. For Medicaid members, HHSC may require the use of other assessment instruments/outcomes measures in addition to the DSM.

Providers must document DSM diagnoses and any assessment or outcome information in the Member's medical record.

The Member's medical record must document dates of follow-up or next appointments, as well as any discharge plans. Post-discharge appointments are to occur within 7 days of discharge.

Missed Appointments

When a member fails to keep an appointment, the provider office is to contact the member to reschedule. It also should be noted that a member cannot be billed for the missed appointment.

Members discharged from an inpatient psychiatric facility need to have a follow-up appointment within 7 days from the date of discharge. If the member misses an appointment scheduled within 7 days of discharge from an inpatient setting, the provider office must contact the member within 24 hours to reschedule the appointment.

Routine, Urgent and Emergent Services

Routine Behavioral Health Services means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.

Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within twenty-four (24) hours but which does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.

Emergency Behavioral Health Condition means any condition, without regard to the nature or cause of the condition, which in the opinion of prudent layperson possessing an average knowledge of health and medicine:

- requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or
- Which render Members incapable of controlling, knowing or understanding the consequences of their actions.

Authorizations Information

How to Request an Authorization:

To obtain a prior authorization, please fill out the appropriate **Molina Healthcare BH forms** completely and fax to number located on top of the request form **Fax: 1-866-617-4967**. Forms may be found on our website, MolinaHealthcare.com.

Please refer to previous sections regarding **benefit limitations** and **prior authorization requirements** for CHIP, CHIP Perinate, STAR, STAR+PLUS and MMP.

Consent for Disclosure of Information

Providers are required to obtain consent for the disclosure of information from the Member permitting the exchange of clinical information between the behavioral health provider and the Member's physical health provider.

Focus Studies

Molina Healthcare conducts annual focus studies on the coordination of care and continuity of services for both behavioral and medical providers. Members are encouraged to actively participate in the selection of their BH practitioner and may speak with a Molina clinical representative at any time to coordinate their behavioral care. Molina also runs annual focus studies to ensure member satisfaction with the services delivered through the Behavioral Health Hotline.

Utilization Management Reporting Requirements

Molina addresses utilization management requirements through the use of an annual chart audit review to ensure provision of services by behavioral health providers is in accordance with both state and federal regulations. The chart audits may include but are not limited to treatment plan reviews, assessment of services delivered by licensed clinical staff, a listed complete DSM diagnosis and adherence to PHI standards.

Quick Reference Phone List for BH Services

Contact	Telephone/Fax/Prompt
Behavioral Health Crisis Hotline	(800) 818-5837
Behavioral Health Prior Authorization	(866) 449-6849 (Phone) 1-866-617-4967 (Fax)
Provider Services Department <ul style="list-style-type: none"> ▪ Contract Terms ▪ Contract Status ▪ Provider Changes ▪ Information on Education In-Services ▪ Member Eligibility ▪ Benefit Verification 	(855) 322-4080
Claims Call Provider Services for Questions. Call (855) 322-4080	
Paper Claims Molina Healthcare Attn: Claims PO Box 22719 Long Beach, CA 90801	Electronic Claims Payor ID: 20554 Payor ID is for use with all claim's clearinghouses
Paper Appeals Molina Healthcare Attn: Appeals P.O. Box 165089 Irving, TX 75016	

Behavioral Health forms can be found at MolinaHealthcare.com

Chapter 16 - Nursing Facility Benefit

Nursing Facility Benefits for STAR+PLUS Members and MMP Enrollees

Nursing facility services are provided through STAR+PLUS statewide and are intended to improve quality of care for current nursing facility residents and promote care in the least restrictive, most appropriate setting

Nursing Facility Covered Services

- Nursing facility covered services include state and federally mandated services accounted for in the NF Unit daily rate.
- Add-In Services: Physical Therapy, Occupational Therapy, Speech Therapy, Customized Power Wheelchairs (CPWC), Augmentative Communication Device (SCD), Ventilator Care and Tracheostomy Care.

Nursing Facility Excluded Services

- Hospice services are paid out of traditional Medicaid fee-for-service.
- Preadmission Screening and Resident Review (PASRR) services will be excluded from the capitation.

Claims Submission Process and Guidelines

- Nursing facilities may submit claims to their participating MCOs via an established portal through HHSC, through Molina's eportal or through the Nursing Facility's clearinghouse.
- Nursing Facility providers must file claims within 365 days of date of service (DOS).
- MCOs are required to adjudicate Nursing Facility claims within 10 days.
- Claims submitted by a Nursing Facility must meet HHSC's criteria for clean claims submissions described in UMCM Chapter 2.3 "Nursing Facility Claims Manual."

Claims may be sent via paper or through Electronic Submission.

For Paper Claims please send to:
Molina Healthcare of Texas,
Inc. PO Box 22719
Long Beach, CA 90801

For Claims sent Via EDI use electronic payor ID number: 20554

Nursing Facility Unite Rate

Nursing Facility Unite rate means the type of services included in the HHSC daily rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services and over-the-counter drugs. The Nursing Facility

Unit Rate also applicable nursing facility rate enhancements and professional and general liability insurance. Nursing Facility Unit Rate excludes Nursing Facility Add-On Services.

Nursing Facility Medicare Coinsurance Claim (MMP Only)

Molina will pay the State's Medicare coinsurance obligation for qualified Dual Eligible Member's Medicare-covered stay in a Nursing Facility. Molina is not responsible for the State's cost sharing obligation for Dual Eligible Members' Medicare-covered Nursing Facility Add-on Services, which are adjudicated by either the State's fee-for-service claims administrator or the Dual Eligible Member's Medicare plan, as applicable to the Member.

The Nursing Facility must submit an electronic version of the Medicare Remittance and Advice form with the Nursing Facility Coinsurance claim.

Nursing Facility Medicare Coinsurance Claim Deadlines (MMP Only)

Nursing Facility Providers must file Nursing Facility Medicare Coinsurance claims by the later of:

- 365 Days after the date of service; OR
- 95 Days after the date of the Remittance and Status (R&S) Report explanation or payment from another carrier or contractor

If the Nursing Facility Provider files a claim for Nursing Facility Medicare Coinsurance with a third-party insurance resource, the wrong health plan, or with the wrong HHSC portal, and produces documentation verifying that the initial filing met the timeliness standard cited above, Molina will process the claim without denying the resubmission for failure to timely file.

Nursing Facility Coinsurance Claims not submitted within 365 days of service or within 95 days after the date of the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor will be denied for failure to file timely.

Nursing Facility Provider Complaints and Appeals

MHT will advise Providers and refer them to the MHT Provider Manual that documents Molina's Provider Complaint and Appeals policy in order to resolve the provider issue(s) in a timely manner in accordance with MHT policies, Federal, State of Texas and HHSC regulations. MHT will advise the provider of the final resolution regarding the complaint within 30 days from the date the initial complaint was received. The provider must file a request for appeal within 30 days from the receipt of the notice of the action. The Molina Appeals and Complaints Coordinator will send a letter to the provider within 5 business days acknowledging receipt of the appeal. MHT will advise the provider of the final disposition of their appeal within 30 calendar days after receipt of the initial written or oral request for an appeal.

Chapter 17 – Long-Term Services and Supports (LTSS)

LTSS Overview

LTSS includes both Long-Term Care (LTC) and Home and Community Based Services (HCBS). Long-Term Care programs are when an individual is living in a facility-based care setting (such as a nursing home or intermediate care facility). Home and community-based services programs provide alternatives to living in facility-based care settings. These programs empower consumers to take an active role in their health care and to remain in the community. The programs serve people who are older adults, people with intellectual and/or developmental disabilities, or people with disabilities.

Molina understands the importance of working with our providers and Community Based Organizations (CBO's) in your area to ensure our members receive LTSS services that maintain their independence and ability to remain in the community.

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

LTSS Services and Molina Healthcare

Long-Term Care and Support Services (LTSS) are benefits that help members stay safe and independent in their home or community. Members can receive LTSS services if they need help with daily healthcare and living needs and meet the level of care eligibility standards. Members who are eligible to receive LTSS services can receive:

- Personal Assistance Services (PAS)
- Day Activity and Health Services (DAHS)
- Community First Choice (CFC) services with Level of Care eligibility include:
 - Personal Assistance Services (PAS)
 - Habilitation Services
 - Emergency Response Services
 - Support Management

Other STAR+PLUS and MMP members can receive additional long-term care services based on their medical need. These are called STAR+PLUS Waiver Services. They include:

- Adaptive aids, such as some wheelchairs and some durable medical equipment
- Adult Foster Care
- Assisted Living Facility
- Consumer Directed Services
- Emergency Response Services
- Home Delivered Meals

- Minor Home Modifications
- Nursing Facility Services
- Personal Care Attendant
- Respite Care
- Therapy Services (physical, occupational, speech)
- Protective Supervision
- Transition Assistance Services
- Dental Services
- Cognitive Rehabilitation Therapy
- Employment Assistance
- Supported Employed

LTSS Benefits and Approved Services

Members who are eligible to receive LTSS services can receive:

- Community First Choice (CFC): Available to all Medicaid-eligible members who meet an institutional level of care for a hospital, nursing facility, intermediate care facility for individuals with an intellectual disability or related condition. CFC services include:
 - Personal Assistance Services (PAS): services designed to help with daily living activities and health-related tasks
 - Habilitation Services: services to help members learn new skills and care for themselves
 - Emergency Response Services: services to help if members live alone or are alone for most of the day
 - Support Management: training on how to select, manage and dismiss attendants
- Personal Assistance Services (PAS): includes assisting the member with performance activities of daily living and household chores necessary to maintain the home in a clean, sanitary and safe environment. The level of assistance provided is determined by the member's needs and the plan of care
- Day Activity and Health Services (DAHS): includes nursing and personal assistance services, therapy extension services, nutrition services, transportation services and other supportive services.

STAR+PLUS Waiver Services include, but are not limited to:

- Adaptive aids: medical equipment and supplies that include devices, controls or appliances specified in the plan of care that enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment where they live.
- Adult Foster Care: A 24-hour living arrangement for persons who, because of physical or mental limitations, are unable to continue residing in their own homes. Services may include meal preparation, housekeeping, personal care, help with activities of daily living, supervision and the provision of or arrangement of transportation
- Assisted Living Facility: A 24-hour living arrangement in licensed personal care facilities in which personal care, home management, escort, social and recreational activities, 24-hour supervision, provision or arrangement of

transportation, and supervision of, assistance with and direct administration of medications are provided.

- **Emergency Response Services:** an electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in the community or at high risk of institutionalization. In an emergency, the member can press a call button to signal for help. The electronic monitoring system helps ensure that the appropriate persons or service provider response to an alarm call from the member.
- **Home Delivered Meals:** services that provide nutritionally sound meals delivered to the member's home.
- **Minor Home Modifications:** services that assess the need for, arrange for and provide modifications and/or improvements to an individual's residence to enable the individual to reside in the community and to ensure safety, security and accessibility.
- **Nursing Facility Services:** includes, but are not limited to, assessing and evaluating health problems and the direct delivery of nursing tasks, providing treatments and health care procedures ordered by a physician and/or required by standards of professional practice or state law, delegating nursing tasks to unlicensed persons according to state rules promulgated by the Texas Board of Nursing, developing the health care plan and teaching individuals about proper health maintenance.
- **Personal Attendant Services:** includes assisting the member with the performance of activities of daily living and household chores necessary to maintain the home in a clean, sanitary and safe environment. The level of assistance provided is determined by the member's needs and the plan of care.
- **Respite Services:** temporary relief to persons caring for functionally impaired adults in community settings other than Adult Foster Care homes or Assisted Living Facilities. Respite services are provided in-home and out-of-home and are limited to 30 days per individual service plan year. Room and board is included in the payment for out-of-home settings.
- **Therapy Services (physical, occupational, speech):** evaluation and treatment of impairments, disorders or deficiencies related to the neuro-musculo-skeletal systems, member's speech and language. Services include the full range of activities provided by a physical therapist or licensed physical therapy assistant under the direction of a licensed physical therapist, speech pathologists and language pathologists under the scope of their state licensure.
- **Protective Supervision:** services provided solely to ensure the health and welfare of a member with cognitive/memory impairment and/or physical weakness.

Transition Assistance Services: assists members with non-recurring set-up expenses for transitioning from nursing homes to the community. Services may include assistance with security deposits for leases on apartments or homes, essential household furnishings, set-up fees for utilities, moving expenses, pest eradication or one-time cleaning.

- **Dental Services:** the services provided by a dentist to preserve teeth and meet the medical need of the member. Allowable services include

emergency dental treatment necessary to control bleeding, relieve pain and eliminate acute infection; preventative procedures required to prevent the imminent loss of teeth; the treatment of injuries to teeth or supporting structures; dentures and the cost of preparation and fitting; and routine procedures necessary to maintain good oral health.

- Cognitive Rehabilitation Therapy: a service that assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions.
- Employment Assistance: services that assist the member with locating competitive employment or self-employment.
- Supportive Employment: services that assist the member with sustaining competitive employment or self-employment.

STAR Members under 21 years old with disabilities in all Service Areas, including the Medicaid Rural Service Area, may be eligible for certain Community-based Long-Term Care Services. Providers can contact the UM department at (855) 322-4080 for additional information and can refer to the TMPPM for information on the appropriate billing practices for these services.

Getting Care, Getting Started

Molina Service Coordinators will engage with members and routinely assess for barriers and opportunities to coordinate medical, behavioral health, and LTSS services. Specifically, Service Coordinators provide verbal, written and/or alternate format information on:

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

At a minimum, the Service Coordinator's name and their contact information and hours of availability are provided to the member. All Service Coordinators are required to keep email and voicemail current with availability or backup as necessary for members and their providers.

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

- LTSS Service Coordination
- Care and Service Plan Review (if applicable)
- Crisis Intervention
- Event Based Visits
- Institution-based Visits
- Service Management Medicaid Resolution
- Assessment of LTSS Need
- Member Education

Molina will work closely with the various Community Based Organizations (CBO's) for home and community-based services (HCBS) to ensure that the member is getting the care that they need.

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

Care Management Team or Integrated Care Team

All LTSS members will receive service coordination and be assigned a Service Coordinator from Molina.

The care management team for LTSS will include at a minimum the member and/or their authorized representative, Service Coordinator, and PCP.

The person-centered Integrated Care Team (ICT) will include at minimum the member and/or their authorized representative, Service Coordinator and anyone a member requests to participate. ICT members may also include LTSS providers (e.g. *Services Facilitator, Adult Day Health Care Center staff assistive technology, transition coordinator, Nursing Facility staff, etc.*), PCP, specialist(s), behavioral health clinician, Targeted Case Management service providers, and pharmacist. The ICT can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required members.

Individual Service Plan Coordination (Available for Waiver Services)

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

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

A Person-Centered Service Plan means the plan that documents the amount, duration, and scope of the home and community-based services. The service plan is person centered and must reflect the services and supports that are important for the member to meet their needs, goals and preferences that are identified through an assessment of functional need. The service plan will also identify what is important with regard to the delivery of these services and supports (42 CFR 441.301).

The Individual Service Plan (ISP) will be developed under member's direction and implemented by assigned members of the Interdisciplinary Care Team (ICT) no later than the end date of any existing SA or within the state specific timeframes for initial and reassessments. This applies to members who require an ISP. All services and changes to services must be documented in the ISP and be under the direction of the member in conjunction with the Service Coordinator.

The Integrated Care Team (ICT) is identified by the member and at a minimum may include the member, the Service Coordinator and PCP. Under member's direction, the ICT is responsible for developing the ICP, and is driven by and customizable according to the needs and preferences of the member. As a provider you may be asked to be a part of the ICT.

Additional services needed are assessed at least on an annual basis or upon a significant change in condition and a can be requested through the member's Service Coordinator. Additional services needed may be identified by the member, the service coordinator, and/or the ICT team. Once an additional need is established, the care plan will be updated with the member's consent and additional services approved. For additional information regarding LTSS service coordination and approvals in the member's ICP, please contact Molina Healthcare of Texas at (866) 409-0039.

Transition of Care Programs

Molina has goals, processes and systems in place to ensure smooth transitions between member's setting of care and level of care. This includes transitions to and from inpatient settings (i.e. Nursing Facility to Home).

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

Continuity of Care (COC) Policy and Requirements

Molina will allow for the safe transition of members while adhering to minimal service disruption. In order to minimize service disruption, Molina will honor the member's existing service plans, level of care, and providers (including out-of-network providers) for 90 days or until the current authorization expires; unless a different timeframe is specified by HHSC.

Ongoing provider support and technical assistance will be provided especially to community behavioral health, LTSS providers, and out of network providers during the continuity of care period. All existing Integrated Service Plans (ISPs) and Service Authorizations (SAs) will be honored during the transition period of 90 days or until the current authorization expires; unless HHSC specifies a different timeframe.

A member's existing provider may be changed during the transition period only in the following circumstances: (1) the member requests a change; (2) the provider chooses to discontinue providing services to a member as currently allowed by Medicaid; (3) Molina or HHSC identifies provider performance issues that affect a member's health or welfare; or (4) the provider is excluded under state or federal exclusion requirements.

Out-of-network providers who are providing services to members during the initial continuity of care period shall be contacted to provide them with information on becoming credentialed, in-network providers. If the provider chooses not to join the network, or the

member does not select a new in-network provider by the end of the transition period, Molina will work with the member in selecting an in-network provider.

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

Members must receive initial contact from Molina within 30 days of enrollment.

For additional information regarding continuity of care and transition of LTSS members, please contact Molina Healthcare at (855) 322-4080.

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

In a consumer-directed model, the state requires Molina to maintain contracts with Financial Management Service Agencies.

The following services can be consumer directed:

- Primary Home Care (PHC)
- Personal Assistance Services or acquisition, maintenance and enhancement of skills
- Habilitation
- Personal Attendant Services (PAS),
- Respite
- Nursing,
- Therapies (Physical, Occupational, and/or speech/language therapy)

Credentialing

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

Appeals, Grievances, and State Hearings

Molina follows the standard appeals, grievances and state hearing process for LTSS providers. Please see Chapter 11 for more information on Complaints and Appeals.

Member Complaints/Grievances and Appeals

Molina follows the standard process for member complaints/grievances and appeals regarding LTSS services. Please see Chapter 11 for more information on Complaints and Appeals.

Claims for LTSS Services

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

For more information on how to submit a claims via the Provider Portal, contact your health plan provider services representative at (855) 322-4080.

Billing Molina

For detailed billing information see Chapter 2.

Atypical Providers

Atypical providers are service providers that do not meet the definition of health care provider. Examples include taxi services, home and vehicle modifications, insect control, habilitation and respite services, etc. Although, they are not required to register for an NPI, these providers perform services that are reimbursed by Molina Healthcare of Texas.

Atypical providers are required to use their Medicaid Identification Number given to them by the state of Texas to take the place of the NPI.

When billing Molina Healthcare for LTSS Services, refer to the Appendix for more detailed information.

Claims Submission: Web-Portal

We encourage our LTSS providers to utilize the Molina web portal to submit claims. Please see the Claims Submission section in Chapter 2 or the Web-Portal Quick Reference Guide (<http://www.molinahealthcare.com/webportaldocs/Providers/UserManual/Quick%20Reference%20Guide.pdf>) for further details. You may also contact your Provider Services Representative for additional information.

Appendix: HCBS Codes

For reference, the Home and Community Based Services Codes for Texas are available in the LTSS Rate Grid located at MolinaHealthcare.com.

Appendix: Nursing Facility Billing Guidance

For reference, the Nursing Facility Billing Guidance for Texas is available in The Nursing Facility Provider manual located at MolinaHealthcare.com.

Chapter 18 – Community First Choice

Community First Choice

Senate Bill 7 from the 2013 Texas Legislature directs the Health and Human Services Commission to implement a cost-effective option for attendant and habilitation services for members with disabilities. A federal state plan option, called Community First Choice (CFC), allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities.

The CFC service array is designed to offer home and community-based services as cost-effective options for eligible members who receive services according to their specific needs, as defined by a person-centered assessment process.

Agencies contracted with Molina provide services to members living in their own homes or family's home where services are needed. The services provided are identified on a service plan and are authorized by Molina.

Eligibility for Community First Choice Services

To be eligible for the CFC services, a member must:

- be a child or an adult who is eligible for Medicaid;
- require an institutional level of care, such as:
 - a nursing facility;
 - a hospital;
 - an institution of mental disease (under age 21 or 65 or older); or
 - an intermediate care facility for individuals with an intellectual disability or related condition; and
- Need a Community First Choice service

Community First Choice Services

Services provided are tailored to meet the member's goals and needs based upon his or her medical condition, mental and functional limitations, ability to self-manage, and availability of family and other support.

Molina must ensure the member's informed choice and preferences are incorporated into the planning and provision of the member's care. Our Members are included in choice of services, choice of service provider, and when or where services are provided. Our Members actively participate in determining their ongoing plan of care.

While providing care under the standards of professional practice, Molina recognizes and supports the member's right to a dignified existence, privacy and self-determination.

The following Community First Choice services are available:

Personal Assistance Services - This service provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision, and/or cueing. Such assistance is provided to a member in performing ADLs and IADLs based on a person-centered service plan. CFC personal assistance services include:

- Non-skilled assistance with the performance of ADLs and IADLs;
- Household chores necessary to maintain the home in a clean, sanitary, and safe environment;
- Escort services, which consist of accompanying, but not transporting, and assisting a member to access services or activities in the community; and
- Assistance with health-related tasks. Health-related tasks, in accordance with state law, include tasks delegated by a registered nurse, health maintenance activities, and extension of therapy. An extension of therapy is an activity that a speech therapist, physical therapist or occupational therapist instructs the member to do as follow-up to therapy sessions. If appropriate, the member's attendant can assist the member in accomplishing such activities with supervision, cueing and hands-on assistance.

In the consumer-directed services model, the member or legally-authorized representative determines health-related tasks without a nurse assessment, in accordance with state law.

Habilitation - This service assists members with acquisition, maintenance, and enhancement of skills necessary for the member to accomplish ADLs, IADLs, and health-related tasks. This service is provided to allow a member to reside successfully in a community setting by assisting the member to acquire, retain, and improve self-help, socialization and daily living skills, or assisting with and training the member on ADLs and IADLs. Personal assistance may be a component of CFC habilitation for some members. CFC habilitation services include training, which is interacting face-to-face with a member to train the member in activities, such as:

- self-care;
- personal hygiene;
- household tasks;
- mobility;
- money management;
- community integration, including how to get around in the community;
- use of adaptive equipment;
- personal decision-making;
- reduction of challenging behaviors to allow members to accomplish ADLs, IADLs, and health-related tasks; and
- Self-administration of medication.

Emergency Response Service - This service provides backup systems and supports to ensure continuity of services and supports. Reimbursement for backup systems and supports is limited to electronic devices to ensure continuity of services and supports and are available for members who live alone, who are alone for significant parts of the day, or have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Support Management - This service provides voluntary training on how to select, manage, and dismiss attendants.

CFC Service Locations

All CFC services are provided in a home or community-based setting, which include member homes, apartment buildings, and non-residential settings. Community-based settings do not include provider-owned or controlled residential settings, and do not include:

- nursing facilities;
- hospitals providing long-term care services;
- Institutions for Mental Disease (IMD);
- Intermediate Care Facilities for Individuals with an Intellectual disability or Related Condition (ICF-IID); or
- A setting with the characteristics of an institution.

Provider Base

Molina contracts for CFC services with providers, determined to be qualified by Texas, in a program already approved by the Centers for Medicare & Medicaid Services. Providers delivering CFC Habilitation services include licensed home and community support services agencies (HCSSAs), certified Home and Community-based Service and Texas Home Living providers, licensed personal emergency response services agencies, qualified financial management services agencies, and providers hired by individuals using the CDS option who meet qualifications.

General Provider Requirements for Participation

CFC providers must:

- provide the array of services identified through its own employees, subcontractors or personal service agreements with qualified members;
- provide trained and competent staff for member care;
- maintain documentation of the assessment and provision of services; and
- provide for the delegation and supervision of nursing tasks and personal care tasks.

Agencies may subcontract with an individual or a group in order to provide the necessary services, as long as the group designates at least one signature authority for the contract. A document showing signature authority for the person signing is required.

If a provider is not providing services as authorized or meeting their contract requirements, Molina may authorize a change to another provider.

Qualifications for PAS Supervisors

Supervision of a PAS attendant is provided by the Registered Nurse with the contracted provider agency or an individual who has completed two years of full-time study at an accredited college or university. An individual with a high school diploma or general equivalence diploma may substitute one year of full-time employment in a supervisory

capacity in a health care facility, agency or community-based agency for each required year of college.

RNs must:

- have proof of a current license from the Board of Nurse Examiners for the state of Texas; and
- Practice in compliance with the Nurse Practice Act according to the rules and regulations of the Board of Nurse Examiners.

Proof of licensure can be validated by viewing the nurse's original current license and recording in a log the nurse's name, license number, date of expiration and initials of the individual who verified the license is current. If necessary, licenses can be verified with the Board of Nurse Examiners by telephone or written request.

Qualifications of Emergency Response Service Providers

Emergency response service providers must:

- be licensed as a personal emergency response system provider in accordance with 25 TAC Chapter 140, Subchapter B (relating to Personal Emergency Response System Providers); or
- contract with a personal emergency response system provider licensed in accordance with 25 TAC Chapter 140, Subchapter B.

Qualifications of a Financial Management Services Agency (FMSA)

Prior to contracting with an MCO, FMSAs must:

- attend a mandatory three-day training conducted by HHSC; and
- demonstrate knowledge of training material, including the definition and responsibilities of a vendor fiscal employer agent in accordance with IRS Revenue Procedure and an explanation of fiscal employer agent based on Section 3504 of the IRS code and state tax (unemployment) requirements as a Vendor Fiscal/Employer Agent.

An individual service provider must not be the member's legal guardian; the spouse of the member's legal guardian; the member's designated representative; or the spouse of the member's designated representative.

Qualified Habilitation Provider

- A qualified habilitation provider is a contracted entity who provides an integrated array of individually tailored services and supports furnished to an eligible enrolled Molina member which are designed to assist the member to reside successfully in their home, with their families, or in an alternate home.
- Molina will contract with Significant Traditional Providers (STP) who have historically provided habilitation like services through the Home and Community Services (HCS) and Texas Home Living Waivers (TxHmL). Additionally, licensed home health agencies HCSSA (Home and Community Support Services Agencies) will be eligible to provide habilitation services.

- The habilitation provider delivers habilitation to an individual on a daily basis, following the Individualized Plan of Care (IPC) to include:
 - Self-Care (i.e., toileting, bathing, teeth brushing, face/hand washing, grooming, dressing and dining behavior);
 - Communication (i.e., verbal, vocal, gestural, manual and augmentative expressive skills and understanding directional requests for receptive skills);
 - Socialization (i.e., appropriate interaction with others, participatory skills, developing friendships and community behaviors);
 - Leisure/Recreation (i.e. independence with age appropriate instructional/leisure materials, developing interest in sensorimotor activities, participating in community events and cooperative play or recreation activities. These areas of services are based on individual choice and preference and are included on the Individualized Plan of Care.
 - Is responsible for delivery of the identified habilitation services based upon the individual's choice and preferences. The habilitation provider interacts with respect for the person and in a positive manner with the member at all times.

Role of the Qualified Habilitation Provider

- In accordance with the consumer's Individual Support Plan (ISP) processes, assist in developing an individualized support plan, including:
 - Establish individualized, time-limited training objectives/functional outcomes that are based on assessment data and input from the individual/the individual's representative that will allow an individual to achieve his/her long-term goals.
 - Develop strategies for habilitation objectives/functional outcomes within twenty (20) business days after initiating service using the MCO accepted format.
- The specific training strategy for each objective/outcome shall identify the schedule for implementation, the frequency and duration of services, data collection methods, and teaching strategies. A teaching strategy is required for each behavioral outcome identified by the Individual Plan of Care (IPC) and is a series of steps to teach the consumer a single behavioral outcome.
- Develop an initial Implementation Plan and quarterly Implementation Progress Updates

Direct Service Staff Qualifications

- Have at least three (3) months experience implementing and documenting performance in individual programs (specific training strategies);
- Have both three (3) months experience in providing either respite or personal care and have received training, in implementing and documenting performance; or
- Perform three (3) months of habilitation services under the direct supervision of an individual who is qualified to provide habilitation as described above.
- Maintain a current Cardiopulmonary Resuscitation certification.
- When the member has chosen the Consumer Directed Service (CDS) option for self-direction of services, the habilitation direct service staff will

be required to meet the same training standards as identified above. Additional training may be required outside of the basic scope of the required/standard training to include training such as Managing Inappropriate Behaviors, use of informal supports, disease specific trainings, etc.

Habilitation Billing and Record Keeping

- Habilitation services shall be authorized using a unique service code as identified by the HHSC.
- When PAS and habilitation are both authorized, each service will be identified on one authorization with total units to reflect both services.
- When PAS and habilitation are identified for a member, the PAS and Habilitation shall be billed using the habilitation code and reimbursed using the blended rate.
- The Habilitation Provider shall submit quarterly individualized progress reports on the member to Molina and the member/member's representative unless the member/member's representative has requested not to receive them. The provider must submit the MCO specific quarterly reporting format.
- The quarter is based on the calendar year and the reports are due no later than the fifteenth (15) day following the end of the quarter.
- The Habilitation Provider Agency or direct staff when Consumer Directed Services are provided shall maintain daily records on file as proof of the services and number of hours worked by each direct service staff providing direct habilitation service to a member.
- Habilitation providers shall be required to utilize the Electronic Visit Verification (EVV) as mandated by the Texas Health and Human Services (HHSC) and effective 4/1/2016.
- The Habilitation Provider Agency or direct staff when using the CDS option shall maintain data that demonstrates full compliance with all programmatic and contractual requirements with Molina.

Standards for CFC

CFC Program Provider Responsibilities

- The CFC services must be delivered in accordance with the Member's service plan.
- The program provider must have current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration logs (if applicable), and nursing assessment (if applicable).
- The HCS or TxHmL program provider must ensure that the rights of the Members are protected (ex., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive phone calls, etc.)
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the

delegation of nursing tasks. Dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member's health, safety, and welfare. The program provider must maintain documentation of this training in the Member's record.

- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline (800-647-7418).
- The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the MCO financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a Member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could potentially benefit.
- The program provider must prevent financial impropriety toward a Member, including unauthorized disclosure of information related to a Member's finances and the purchase of goods that a Member cannot use with the Member's funds.

Reporting Abuse, Neglect, or Exploitation (ANE) – Medicaid Managed Care

Report suspected Abuse, Neglect, and Exploitation:

MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to the Health and Human Services Commission (HHSC) if the victim is an adult or child who resides in or receives services from:

- Nursing Facility;
- Assisted living facility;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and DADS;
- Adult Day Care Centers; or
- Licensed Adult Foster Care Providers

Contact HHSC at (800) 458-9858

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
 - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to HHSC;
 - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from on the following providers or their contractors:
 - Local Intellectual and Developmental Disability Authority (LIDDA, Local mental health authority (LMHAs), Community Center, or Mental Health Facility operated by the Department of State Health Services
 - A person who contracts with a Medicaid Managed Care Organization to provide behavioral health services;
 - A Managed Care Organization

 - An officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at (800) 252-5400, or in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report of False Reporting

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency (See: Texas Human Resources Code,

Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).

- It is a criminal offense to knowingly or intentionally report false information to DFPS or DADS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Providers must provide Molina with a copy of the abuse, neglect, and exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services (DFPS).

Chapter 19 - Intellectual and Developmental Disability (IDD) Services

Intellectual and Developmental Disability (IDD) Services for STAR+PLUS members

Persons who transitioned into STAR+PLUS for acute care services:

- Individuals receiving services in community-based Intermediate Care Facilities for Individuals with Intellectual Disabilities or Related Conditions (ICF-IID)
- Individuals receiving services in ICF-IID 1915 (c) Waiver:
- Home and Community-based Services (HCS)
- Community Living and Support Services (CLASS)
- Texas Home Living (TxHmL)
- Deaf Blind Multiple Disabilities (DBMD)

Persons not included:

- Individuals residing in a state supported living center
- Dual eligible (receiving Medicare and Medicaid)
- Children and young adults under age 21 receiving SSI or SSI-related services are voluntary

Claims Submission Process and Guidelines

- IDD providers may submit claims to their participating MCOs via an established portal through HHSC, through Molina's eportal or through the Nursing Facility's clearinghouse
- Nursing Facility providers must file claims within 95 days of date of service (DOS)
- MCOs required to adjudicate most IDD claims within 30 days

Claims may be sent via paper or through Electronic Submission. For

Paper Claims please send to:

Molina Healthcare of Texas, Inc.
PO Box 22719
Long Beach, CA 90801

For Claims sent Via EDI use electronic payor ID number: 20554

Chapter 20 - Risk Adjustment Management Program (Medicaid Only)

What is Risk Adjustment?

Risk Adjustment is 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.

Why is Risk Adjustment Important?

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

Your Role as a Provider

As a Provider your documentation in a member's medical record is critical to a Member's quality of care.

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

- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only submit codes for diagnoses confirmed during a face to face visit with the Member.
- Contain a treatment plan.
- Be clear and concise.
- Contain the Member's name and date of service.
- Have the physician's signature and credentials.

RADV Audits

As part of the regulatory process, State and/or Federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Molina is 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 provide medical records to validate the previously submitted data.

Contact Information

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

Chapter 21 - Compliance

Fraud, Waste and Abuse

Introduction

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

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

Mission Statement

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

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a Federal statute that covers fraud involving any Federally funded contract or program. The act establishes liability for any persons who knowingly presents or causes to be presented to be 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 for the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. Government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for

services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act

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

Health care entities like Molina who receive or pay out at least \$5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds by either 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

The Federal False Claims Act and the State Medicaid False Claims Act have Qui Tam language commonly referred to as “whistleblower” provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded 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 will take steps to monitor Molina contracted Providers to ensure compliance with the Law.

Anti-Kickback Statute – Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursement under the Medicare or other Federal health care programs.

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

Sarbanes-Oxley Act of 2002 –Requires certification of financial statements by both the Chief Executive Officer and 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 mis representation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law. (42 CFR § 455.2)

“Waste:” 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 the Medicaid program.

“Abuse:” means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid 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 Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship (Stark Law).
- Altering Claims and/or medical record documentation in order to get a high 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.
- Inappropriate billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in high costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like service that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

The types of questionable Member schemes investigated by Molina include, but are not limited to, 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 they do not suffer from and the Member sells the medication to someone else.

Review of Provider Claims and Claims Systems

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

The claims payment system utilizes system edits and flags to validate those elements of claims that are billed in accordance and standardized billing practices; ensure 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 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 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 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 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 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.

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, 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 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.

Fraud Information - Reporting Waste, Abuse, or Fraud by a Provider or Client Medicaid Managed Care and CHIP

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184
- Visit <https://oig.hhsc.state.tx.us/> and pick "Continue to OIG's Fraud Reporting Form" to complete the online form.

You can report directly to Molina at:

Molina Healthcare of Texas Attn: Director of Compliance
5605 N. MacArthur Blvd., Suite 400
Irving, TX 75038

- Molina Compliance Hotline: (866) 606-3889
- To report an issue online visit: [**https://molinahealthcare.AlertLine.com**](https://molinahealthcare.AlertLine.com)

To report waste, abuse or fraud, get as much information as possible.

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider

- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events and a summary of what happened

When reporting about someone who gets benefits, include:

- The person's name
- The person's date of birth, Social Security Number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse or fraud

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

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

HIPAA Requirements and Information

HIPAA (Health Insurance Portability and Accountability Act) Requirements

Molina Healthcare's Commitment to Patient Privacy

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

Provider Responsibilities

Molina Healthcare expects that its contracted Providers will respect the privacy of Molina Healthcare 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/Practitioners must understand all state and federal healthcare 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 Texas healthcare Providers/Practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
 - a. HIPAA
 - b. The Health Information Technology for Economic and Clinical Health Act (HITECH)
 - c. 42 C.F.R. Part 2
 - d. Medicare and Medicaid laws
 - e. The Affordable Care Act

2. TX Medical Privacy Laws and Regulations

Providers should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and healthcare 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. (See, Sections 164.506(c)(2) & (3) of the HIPAA Privacy Rule.) Disclosure of PHI by one covered entity to another covered entity, or healthcare 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 healthcare 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.” (See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule.)
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/Practitioners to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS and quality improvement.

Confidentiality of Substance Use Disorder Patient Records

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

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Healthcare Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

- **Notice of Privacy Practices**

Providers/Practitioners who are covered under HIPAA and 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/Practitioner should obtain a written acknowledgment that the patient received the notice of privacy practices

- **Requests for Restrictions on Uses and Disclosures of PHI**

Patients may request that a healthcare Provider/Practitioner restrict their uses and disclosures of PHI. The Provider/Practitioner is not required to agree to any such request for restrictions.

- **Requests for Confidential Communications**

Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners must accommodate reasonable requests by the patient.

- **Requests for Patient Access to PHI**

Patients have a right to access their own PHI within a Provider/Practitioner'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/Practitioner 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.

- **Request to Amend PHI**

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

- **Request Accounting of PHI Disclosures**

Patients may request an accounting of disclosures of PHI made by the Provider/Practitioner during the preceding six (6) 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 must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina member and patient PHI. As more providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical - is a rapidly growing problem and that their patients trust 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 strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare Providers are encouraged to submit claims and other transactions to Molina Healthcare 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 advice

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer [.MolinaHealthcare.com](http://MolinaHealthcare.com) for additional information regarding HIPAA standard transactions.

1. Click on the area titled “I’m a Health Care Professional”
2. Click the tab titled HIPAA
3. Click on the tab titled “HIPAA Transactions” or “HIPAA Code Sets”

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions. For Claims with dates of service prior to October 2, 2015, ICD-9 coding must be used. For Claims with dates of service on or after October 1, 2015, Providers must use the ICD-10 codes.

National Provider Identifier

Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina Healthcare 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. Provider must use its NPI to identify themselves on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina. **NPIs must be attested with TMHP. For more information, call Provider Services at (855) 322-4080.**

Additional Requirements for Delegated Providers/Practitioners

Providers who are delegated for claims and utilization management activities are “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;
- Quality of Care issues;
- Regulatory Audits;
- Risk Adjustment;
- Treatment, Payment and/or Operations Purposes; and
- Collection of HEDIS® medical records.



Authorization for the Use and Disclosure of Protected Health Information

Name of Member: _____ Member ID#: _____

Member Address: _____ Date of Birth: _____

City/State/Zip: _____ Telephone #: _____

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

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

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

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

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

5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes ___ No ___

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. Molina Healthcare may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina Healthcare reserves the right to deny that health care.

9. I understand that I have a right to receive a copy of this authorization, if requested by me.

10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that:

- a) action has been taken in reliance on this authorization; or
- b) if this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.

11. I understand that the information I authorize a person or entity to receive may be no longer protected by federal law and regulations.

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

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

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

Chapter 22 - Telehealth

Telehealth and Telemedicine Services

Provider shall comply with all operating policies and procedures adopted by Molina both for providing Telehealth Services, as described below as well as taking into account all other areas of this manual that have implications for telehealth.

Definitions

“Telehealth” and “Telemedicine” are health care services provided to a patient from a health care professional who is at a remote location using telecommunications. “Telehealth is not a separate medical specialty. It is a delivery tool or system.” – American Telemedicine Association Core Guidelines for Telemedicine Operations

“Telehealth” means: a health service, other than telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional’s license or certification who does not perform telemedicine medical service and that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including:

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- Other technology that facilitates access to health care services or medical specialty expertise.

“Telemedicine” means: a medical service, initiated by a physician who is licensed to practice medicine in Texas under Title 3, subtitle B of the Occupations Code or provided a health professional acting under physician delegation and supervision, that is provided for the purposes of patient assessment by a health professional, diagnosis or consultation by a physician, or treatment or for the transfer of medical data, and that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including:

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- Other technology that facilitates access to health care services or medical specialty expertise.

Telepsych is a subset of ‘Telehealth/Telemedicine’. The word ‘Telepsych’ is an alternate term used when the service is offered by a Mental Health (Behavioral Health or Substance Use Disorder) specific provider type.

Following are terms used for locations used for real-time service via telecommunications.

Originating Site = Where the patient is located. Other common names for this term include: spoke site, patient site, remote site, and rural site.

Distant Site = Where the consulting provider is located. Other common names for this term include: hub site, specialty site, provider/physician site, referral site, and consulting site.

Telehealth and Telemedicine Services means:

- Interaction for clinical purposes by a Provider through technology that permits communication between a Member at an originating site and a Participating Provider at a distant site.
- “Originating site” may include home or other location away from clinical setting, as allowed by local regulations.
- This communication is for the purposes of diagnosis, consultation, or treatment, consistent with the provider's scope of practice.
- The communication does not involve in-person contact between the Member and a Participating Provider.
- During the virtual visit the Member may receive in-person support at the originating site from other medical personnel to help with technical equipment and communications with the Participating Provider.
- Services include live interaction through audio and/or video conferencing.
- Digital transmission and evaluation of patient clinical information when the provider and patient are not both on the network at the same time. The Participating Provider may receive the Member’s medical information through telecommunications without live interaction, to be reviewed at a later time (often referred to as “Store and Forward” technology).

Note: “Provider” does not have to be a medical doctor. A variety of health professionals can be involved in telehealth services, as appropriate under industry and state regulations.

Benefits

Benefits are provided for telemedicine services in all Molina Healthcare jurisdictions when provided in accordance with local state requirements and definitions of “Telehealth” or “Telemedicine.” Please see additional guidance outlined below.

Benefits are not provided for any technical equipment or costs for the provision of telemedicine services. The following additional provisions that apply to the use of Telehealth and Telemedicine services:

- 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 i.e. room or building
- Services do not include texting, facsimile or email only.
- Deductibles, copayments, or coinsurances may apply to telemedicine services the same as face-to-face diagnosis, consultation or treatment services.
- State health plan shall provide list of telehealth codes as part of HCS Pre-authorization process.
- For any service which requires pre-authorization for member to access in a face-to-face encounter, Molina also may require pre-authorization for the virtual version to count as a benefit.

Providers should use the “POS = “02”, ‘95’ modifier or code Q3014 when billing telehealth or telemedicine services. Providers should refer to the TMPPM for additional billing procedures.

Member Eligibility and Consent for Telehealth Services

Molina does not discriminate regarding which of our Members may access telehealth services. There are not criteria for their geography or physical proximity to providers. We acknowledge that depending on a Member’s situation, they may find additional convenience through telemedicine even if they live in area with many providers located a short distance from them.

Organizations and Health Professionals providing Telehealth services shall ensure compliance with relevant legislation, regulations, and accreditation requirements for supporting patient/client decision-making and consent.

Provider organizations shall integrate Telehealth into existing operational procedures for obtaining consent for treatment from patients. They shall provide a mechanism for additional informed consent when required for invasive procedures.

From “ATA Practice Guidelines for Live, On Demand Primary and Urgent Care”:

One or more of the following situations means the member is not suitable for care via telehealth:

- Patient has cognitive disorders
- Intoxication
- Cognitive impairment such as autism
- Language barriers e.g. limited ability to speak and understand English, if an interpreter is not available
- Emergency situation warrants escalation to ER visit or 911
- Patient does not have requisite technology to complete virtual visit

Member can be alone during the visit, as long as this complies with state regulations and they are prepared appropriately for telemedicine encounter.

Special Populations:

1. English as a second language – Provide and document use of interpreter.
2. Comply with American Disabilities Act of 1990 (ADA) and other legal and ethical requirements.
3. Pediatric – Encounters require the presence and/or active participation of a caregiver or facilitator, including parent/guardian, nurse, and/or childcare worker. The practitioner shall obtain consent from the parent or legal representative of the child as required by law in the respective jurisdiction. With parental consent, it is acceptable for a minor to have a telehealth session alone without a caregiver or facilitator present in the same room.

- a. Age of Consent: Minors in all states have the right to consent to testing and treatment for a sexually transmitted disease (STD). Minors also have the right to consent to: prenatal care; family planning services.
- b. Abuse: In the evaluation of child abuse and/or sexual abuse, state child protective rules supersede individual Privacy and FERPA regulations for consent.
 - i. Images captured for the evaluation of child abuse and/or sexual abuse shall follow Store and Forward guidance for safety, security, privacy, storage, and transmissions as well as institutional policies.
- c. Homebound / Geriatric – Providers should have the patient affirm consent to family members/caregivers, and nurses that would facilitate the visit and decision-making. If the patient is in a care facility or senior living community, a trained technician may assist in collecting relevant clinical information, including medical records, lab or diagnostic testing, and access to caregivers and staff. Providers should take into account the special needs of the elderly and take these into account when designing and choosing technology configuration for telehealth equipment and systems.

The member or their guardian need to have the option to consent to use of telehealth for services, instead of care delivered in person. This consent shall be documented and include:

- a. Description so patient understands how telehealth service compares to in-person care. Appraise patients of their rights when receiving telemedicine, including the right to suspend or refuse treatment.
- b. Appraise patients of their own responsibilities when participating in telehealth.
- c. Inform patients of a formal complaint or grievance process to resolve ethical concerns or issues that might arise as a result of participating in telehealth.
- d. Record keeping – Process by which patient information will be documented and stored.
- e. Privacy and security – limits to confidentiality in electronic communication. Discuss the potential benefits, constraints and risks (e.g., privacy and security) of telehealth.
- f. Potential Risks – include an explicit emergency plan (particularly for patients in settings without access to clinical staff). The plan should include calling the patient via telephone and attempting to troubleshoot the issue together. It may also include referring the patient to another provider or completing the encounter by voice only.
- g. Credentials of the distant site provider and billing arrangements – Information provided shall be in simple language that can easily be understood by the patient. This is particularly important when discussing technical issues like encryption or the potential for technical failure.
- h. Potential for technical failure – Contingency plan that is communicated to the patient in advance of the telehealth encounter.
- i. Procedures for coordination of care with other professionals
- j. A protocol for contact between visits
- k. Prescribing policies including local and federal regulations and limitations
- l. Conditions under which telehealth services may be terminated and a referral made to in-person care.

- m. Description of appropriate physical environment free from distractions, conducive for privacy and proper lighting/background noise.
- n. Inform patients and obtain their consent when students or trainees observe the encounter.
- o. Patients shall consent in writing prior to any recording of the encounter.

Privacy and Security

Molina expects that its contracted Provider will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member Protected Health Information (PHI).

Please reference the Compliance section of this Manual for additional details.

Geography and Physical Environment for Telehealth Services

Originating Site Environment for Member:

Written instructions to prepare the member to participate in telehealth should explain standards for PHI using telehealth. When the originating site will be located in the community away from a clinical setting, prior to the session the care team should encourage the patient to select an appropriate location that will support a private conversation about their health.

Distant Site Environment for Provider:

Just as for in person visit, during a telehealth interaction the Provider needs to be situated in a location that is conducive to secure private communication with the patient.

The provider shall minimize distraction, background noise and other environmental conditions that may affect the quality of the encounter. For clear visibility online, is helpful to have light facing the provider and reduce background lighting behind them

The environment shall meet standards for privacy and confidentiality

Personal health information not specific to the patient being examined shall not be visible.

Contingency Support for Member

The provider shall have an emergency or contingency plan that is communicated to the patient / staff at originating site in advance of the telemedicine encounter. This includes alternate options to continue communication, if the session dialogue is disrupted or severed due to technical issues.

Fraud and Abuse Protocols

Provider is required to have protocols to prevent fraud and abuse related to delivery of services via telemedicine. These protocols must address:

- (a) Authentication and authorization of users;
- (b) Authentication of the origin of the information;

- (c) The prevention of unauthorized access to the system or information;
- (d) System security, including the integrity of information that is collected, program integrity and system integrity; and
- (e) Maintenance of documentation about system and information usage.

Provider Directory Listing

Molina offers a visual icon in our Provider Online Directory (POD) that indicates whether a provider offers any telehealth services. Please notify your Provider Services representative as soon as possible if your organization adds telehealth capabilities, so we can update this data field and identify this option appropriately.

Claims and Billing

Providers must follow CMS guidelines as well as state level requirements.

For additional information refer to the CMS MLN Matters Number: 901705 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243327.html>

All telehealth claims for Medicaid members must be submitted to Molina with correct codes for the plan type. Use of the telehealth Place of Service (POS) Code 02 certifies that the service meets the telehealth requirements.

Providers can refer to the TMPPM for additional information on appropriate procedure codes and modifiers for Telehealth services.

Subcontract Relationships for Telehealth Services

Provider shall make known to Molina the name(s) of any outside company(ies) that it uses for the provision of Telehealth Services, whether they are technology or clinical subcontractors.

If the role of the subcontractor organizations could include billing the member directly, then they need to be credentialed/established as a participating provider.

Provider shall ensure and certify that a Business Associates Agreement (BAA) is in place with outside organizations with whom they contract for telehealth support. This BAA shall be shared with Molina if requested.

Provider shall consider the option to have their telehealth services /vendors accredited and shall notify Molina if this accreditation is achieved by external organizations e.g. American Telemedicine Association, The Joint Commission and URAC.

Provider shall notify Molina promptly upon becoming aware of a change in its technology platforms or vendor's accreditation. In the event of such a change, Molina and Provider shall discuss any such changes in good faith.

Administrative Standards

For Organizations

Organizations providing services via Telehealth shall follow the standard operating policies and procedures as set by the State of Texas. These also apply to collaborative partnerships, where there are Telehealth services offered,

- a. If the Telehealth operation is a sole entity or part of a solo practice, that entity or solo practice shall have policies and procedures in place that responsibly include and address aspects of Telehealth as part of governance of all administrative functions with regards to:
 - 1) Human resource management;
 - 2) Privacy and confidentiality;
 - 3) Federal, state, and other credentialing and regulatory agency requirements;
 - 4) Fiscal management;
 - 5) Ownership of patient records;
 - 6) Documentation;
 - 7) Patient rights and responsibilities;
 - 8) Network security;
 - 9) Telehealth equipment use; and
 - 10) Research protocols
- b. Organizations providing Telehealth programs shall have in place a systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting, requirements for outcomes management.
- c. Organizations shall have a mechanism in place for assuring that patients are aware of their rights and responsibilities with respect to accessing health care via Telehealth technologies, including the process for communicating complaints.

For Health Professionals

Provider Credentialing and Licensure for Telehealth

Providers shall follow federal, state, and local regulatory and licensure requirements related to their scope of practice and shall abide by state board and specialty training requirements.

Molina does not maintain specific credentialing beyond state standards for providers who deliver services via telehealth.

The member's geographic location at Originating Site affects the requirements for the provider. Telemedicine services must be in compliance with the state level requirements

for the member's location during these services. Provider shall ensure that the patient is physically located in a jurisdiction in which the provider is duly licensed and credentialed. Typically, Telehealth Services must be provided by providers who are licensed to practice medicine within the state where the member physically is located at time of service.

The following guidelines apply in order to be eligible to receive reimbursement for Telehealth Services.

- All providers must be successfully complete standard credentialing by Molina.
- If the state also requires any type of license for delivery of telemedicine services, this must be documented for Molina as part of the credentialing process.
- Geography: Telehealth Services must be provided by providers who are licensed to practice medicine within the state where the member physically is located at time of service.

Scope of practice:

- a. Health Professionals shall be aware of their locus of accountability and any/all requirements (including those for liability insurance) that apply when practicing Telehealth in another jurisdiction.
- b. Health Professionals using Telehealth shall be cognizant of when a provider-patient relationship has been established within the context of a telemedicine Encounter between the health care provider and the patient, whether interactive or store-and-forward, and proceed accordingly with an evidence-based, best possible standard of care.
- c. Health Professionals providing Telehealth Covered Services shall have the necessary education, training/orientation, and ongoing continuing education/professional development recommended for their scope of practice to ensure they possess the necessary competencies for the safe provision of quality health services in their specialty area.
- d. Health Professionals shall have the requisite training and ensure ongoing compliance with HIPAA and the HITECH Act in their provision of a telemedicine Encounter.

Clinical Standards

- a. Telemedicine providers shall determine the appropriateness of telemedicine on a case-by-case basis. Especially when the originating site is a professionally unsupervised setting (e.g. patient's home), the provider shall evaluate whether the patient can remain safe and handle the more active role required for the treatment process away from in-person settings.
- b. For treatment occurring over several or more sessions over time: the provider should evaluate ongoing the appropriateness of using telehealth format for care delivery. If there is any concern that the patient could be better served through services in person, then the provider should communicate this change to the patient and support transitioning their sessions to face-to-face care if possible or to or with another provider as necessary.

- c. Provider shall respect patient's wishes for format of care i.e. patient has the right to decline starting care via telehealth, and also may request to switch from telehealth to care delivered in person with the same provider or another practitioner as appropriate.
- d. The Organization and Health Professionals shall be satisfied that Health Professionals providing care via Telehealth are aware of their own professional discipline standards and those standards shall be upheld in the Telehealth encounter, considering the specific context, location, and timing, and services delivered to the patient.
- e. Health Professionals shall be guided by professional discipline and national existing clinical practice guidelines when practicing via Telehealth. It will be beneficial to review specialty society guidelines and evidence published in peer-reviewed literature. Any modifications to specialty-specific clinical practice standards for the Telehealth setting shall ensure that clinical requirements specific to the discipline are maintained.
- f. Provider-directed patient self-examination to include the use of peripheral devices as appropriate. This examination may include a demonstration, or an explicit physician-guided self-examination required to confirm the diagnosis, the provider shall recommend to the patient that such testing be performed in accordance with standards of medical care.
- g. Covered Services provided through Store and Forward technology, must include an in-person office visit to determine diagnosis or treatment.

Clinical Documentation for Legal and Regulatory Considerations:

Providers should be aware if the patient is physically located in a jurisdiction in which the provider is duly licensed and credentialed. Providers should document the patient's physical location at the time of the telehealth encounter. If the patient is not located at a known originating site, then the provider should document the patient's stated location in the medical record.

Special Considerations: These may vary by state for pediatrics which include, but are not limited to: consent, parental presence, requirements for establishing a physician-patient relationship, prescribing, prescribing controlled substances, handling of images, and age of majority.

Provider shall provide the originating site with their contact information, including telephone, practice address, and email. It is not necessary for the provider to reveal their specific location to the patient, especially if the provider is located at home at the time of service.

Emergent Encounters via Telehealth:

Providers will document:

1. The process of treating emergent situations, which may include phoning the receiving facility in advance of the patient's arrival.
2. Document all referrals to EMS (dialing 911) including the medical indication/basis for the recommendation, and nature of the problem
3. Document the location of the patient at the start of the encounter

4. Document any extenuating circumstances or adverse events, be they technical or clinical, which occurred during the encounter.
5. Documentation should adhere to all medical-legal standards of care, and if appropriate, insurance requirements for future review and audit.

Technical Standards

- a. Organizations shall ensure that equipment sufficient to support diagnostic needs is available and functioning properly at the time of clinical encounters.
- b. Organizations shall maintain current versions of hardware and software systems and applications.
- c. Organizations shall have strategies in place to address the environmental elements of care necessary for the safe use of Telehealth equipment.
- d. Organizations shall comply with all relevant safety laws, regulations, and codes for technology and technical safety, as well as those required by HIPAA's Security Rule and HITECH Act.
- h. Organizations shall have infection control policies and procedures in place for the use of Telehealth equipment and patient peripherals that comply with organizational, legal, and regulatory requirements.
- i. Organizations providing Telehealth services shall have policies and procedures in place to comply with local legislated and regulatory rules for protection of Patient Protected Health Information and to ensure the physical security of Telehealth equipment and the electronic security of data.
- j. Organizations shall have appropriate redundant systems and communications plans in place that ensure availability of the network for critical connectivity. This includes clinical video and exam equipment for critical clinical encounters and functions.
- k. Organizations shall have plans in place to provide support for the patient and provider in case of technical malfunction during a telehealth session.
- l. Organizations shall meet required published technical standards for safety and efficacy for devices that interact with Members or are integral to the diagnostic capabilities of the practitioner when and where applicable.
- m. Organizations providing Telehealth services shall have processes in place to ensure the safety and effectiveness of equipment through on-going maintenance and review of performance.

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

Glossary

Asynchronous or “store and forward” – Transfer of information from one site to another through the use of a camera or similar device to record an image or data.

Distant or hub site – Site at which the provider delivering the service is located.

Distant site practitioner – Provider at a distant site who furnishes and receives payment for covered telehealth services.

Originating or Spoke site – Location of the patient at the time the service is provided. Remote patient data transfer—Remote data transfer requires no active participation by the patient. The treating provider uploads and sends imaging or pathologic information to a remote consultant for interpretation. This transmission generally is asynchronous.

Remote patient monitoring—Remote monitoring of patient data does not convey verbalized communication by the patient. Biophysical data (e.g., cardiac telemetry) is transmitted to a physician or medical facility for synchronous or asynchronous interpretation.

Synchronous – Simultaneous data information transfer in both directions.

Telehealth—Telemedicine may be considered a part of the global term "telehealth." In common use it refers to a patient encounter with a provider by electronic means either synchronously or asynchronously.

Video Consultation—The patient is in live synchronous video and audio communication with the provider.

Resources for Telehealth Policies, Best Practices and Regulations

American Telemedicine Association – guidelines, regulations, accreditation
<http://www.americantelemed.org>

ATA References

Core Guidelines for Telemedicine Operations

Practice Guidelines for Live, On Demand Primary and Urgent Care

Practice Guidelines for Video-Based Online Mental Health Services

The Joint Commission - accreditation

<https://www.jointcommission.org/>

URAC - accreditation

<https://www.urac.org/programs/telehealth-accreditation>

Center for Connected Health Policy

<http://www.cchpca.org/>

Regional Telehealth Resource Centers

<https://www.telehealthresourcecenter.org/>

Chapter 23 - Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our members with high quality, cost effective drug therapy. Molina works with our providers and pharmacies to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter drugs.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T Committee is organized to assist Molina with managing pharmacy resources and to improve the overall satisfaction of Molina Members and Providers. It seeks to ensure Molina Members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy Network

Members must use their Molina ID card and their Texas Benefits Medicaid card to get prescriptions filled. Members can find a drugstore in their provider directory. Members must go to a Molina network pharmacy, and we can help them find one. Members can call Member Services for more information. This call is free.

Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting www.MolinaHealthcare.com or calling Molina at (855) 322-4080.

Out-of-Network Pharmacies

Members must go to a Molina network pharmacy for the prescription to be covered, and we can help them find one. Members can call Member Services for more information on network drug stores. This call is free.

Members should call us if they are out of state and need emergency prescriptions. We can help find them a Molina pharmacy. If there are no Molina pharmacies, members will have to pay for their prescription that is on the medication drug list. They will have to send us the receipt so Molina can pay them back for medically necessary medications in the quantity needed until they can have a prescription filled at a Molina network pharmacy.

Drug Formulary

The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. Information on procedures to obtain these medications is described within this document and is also available on the Molina website at www.MolinaHealthcare.com.

How do I find a list of covered drugs?

Only those drugs listed in the latest edition of the Texas Medicaid/CHIP Vendor Drug Program (VDP) formulary are covered. Please refer to the Texas Medicaid/CHIP VDP formulary at <http://www.txvendordrug.com/>. HHSC offers a free subscription service for accessing the Drug Formulary through the internet and hand-held devices. This services is called Epocrates and can be found at: <https://www.txvendordrug.com/formulary/epocrates>.

How do I find a list of preferred drugs?

The Texas Medicaid/CHIP VDP formulary and Preferred Drug List (PDL) contains the preferred drugs within the most commonly prescribed therapeutic categories. The PDL is comprised of drug products reviewed and approved by the Texas Pharmacy and Therapeutics (P&T) Committee.

Over-the-Counter (OTC) medications specified in the Texas State Medicaid plan are included in the formulary and on the PDL and may be covered if prescribed by a licensed prescriber. OTC medications are generally not covered for CHIP members; however, may exceptions exist.

To prescribe medications that are listed as non-preferred on the formulary and on the PDL, please call Molina Provider Services Toll Free at (855) 322-4080 for prior authorization. Please refer to the Texas VDP PDL at <http://www.txvendordrug.com/>. HHSC offers a free subscription service for accessing the PDL through the internet and hand-held devices. This services is called Epocrates and can be found at: <https://www.txvendordrug.com/formulary/epocrates>.

Formulary Medications

In some cases, Members may only be able to receive certain quantities of medication Information on limits are included and can be found in the formulary document.

Formulary medications with PA may require the use of first-line medications before they are approved.

Quantity Limitations

Quantity limitations have been placed on certain medications to ensure sage and appropriate use of the medications.

What if a member needs more than 34 days of a prescribed medication?

The pharmacy can only give members the amount of a medication that is needed for the next 34 days. For any other questions, members can call Member Services.

Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular member or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form. Clinical evidence must be

provided and is taken into account when evaluating the request to determine medical necessity.

Generic Substitution

Generic drugs should be dispensed when available. If the use of a particular brand name becomes medically necessary as determined by the Provider, Pa must be obtained through the standard PA process.

New to Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first six (6) months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

Medications not covered by Medicaid are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are not part of the benefit.

Submitting a Prior Authorization Request

Molina will only process completed PA request forms, the following information MUST be included for the request form to be considered complete.

- Member first name, last name, date of birth and identification number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity and directions of use
- Diagnosis

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing, Molina will either fax or call your office to request clinical information be sent in for complete review. To avoid delays, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Medication PA Request form to Molina at (888) 487-9251. A blank Medication PA Request Form may be obtained by accessing www.MolinaHealthcare.com or by calling (855) 322-4080.

Getting Medications

If a member cannot leave home, Molina can provide them with mail order pharmacy. This is done by CVS Caremark Mail Services. Members should call Molina Member Services at: (866) 449-6849/ (877) 319-6826 (CHIP RSA), and we will tell them how to get mail delivery. Some of the pharmacies also have delivery service. Members can check with their local pharmacy to see if they provide this service

If Members have problems getting their medications, they should call Member Services at: (866) 449-6849/ (877) 319-6826 (CHIP RSA).

Prescription Approval

If the member's doctor cannot be reached for prescription approval, the pharmacy may give the member a three-day emergency supply of the drug on the prescription.

Lost Medication

If a prescription is lost or stolen, the pharmacy can call Molina for authorization to give early refill prescriptions.

Over the Counter Medication for CHIP Members

The pharmacy cannot give members an over the counter medication as part of their/their child's CHIP benefit. If a member/their child needs an over the counter medication, they will have to pay for it.

Additional Pharmacy Information

What if a member needs birth control pills?

The pharmacy cannot give members birth control pills to prevent pregnancy. Members can only get birth control pills if they are needed to treat a medical condition.

How do CHIP Perinate members get their medications?

Molina covers most of the medicines an unborn child's doctor would need. The member's doctor will write a prescription, so they can take it to the drug store, or the doctor may be able to send the prescription to the drug store for the member. There are no co-payments required for CHIP Perinate Members.

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

Molina reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment. For children (birth through age 20), Molina also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must enroll with Molina.

To participate as a DME provider, pharmacies must complete the enrollment application available at tmhp.com. All claims for DME items require a completed Title XIX Physician Order form:

- [Title XIX Physician Order form](#)
- [Title XIX Physician Order form instructions](#)

Pharmacies can call (855) 322-4080 for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

Member and Provider “Patient Safety Notifications”

Molina has a process to notify Members and Providers regarding a variety of safety issues which includes voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA accredited organization.

Specialty Pharmaceuticals, Injectables and Infusion Services

Many specialty medications are covered by Molina through the pharmacy benefit using national drug codes (NDCs) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications maybe covered through the medical benefit using Healthcare Common Procedure Coding System (HCPC) J-codes via paper or electronic medical claims submission. Molina, during the utilization management review process, will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any Federal or State regulatory requirements, and the Member-specific benefit plan coverage prior to determination of benefit processing.

If it is determined to be a Pharmacy benefit, Molina’s pharmacy vendor will coordinate with Molina and ship the prescription 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 Services Representative with any further questions about the program.

Newly FDA approved medications 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. “Buy-and-bill” drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursement.

Pain Safety Initiative (PSI) Resources

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

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

Forms

To Access all updated provider forms please go to our provider website at:
MolinaHealthcare.com

Clinical Practice Guidelines

ASTHMA

- Based on the National Heart Lung and Blood Institute of National Institutes of Health Practical Guide for the Diagnosis and Management of Asthma 2007.
- Access the NHLBI Guidelines at: www.nhlbi.nih.gov/guidelines/asthma/index.htm
- Changes to previous year's guidelines? Yes

DIABETES

- Based on the American Diabetic Association Standards of Medical Care for Patients with Diabetes Mellitus. Diabetes Care, Volume 33, Supplement 1, Page S11-S61, January 2010.
- Access Clinical Practice Recommendations directly at: http://care.diabetesjournals.org/content/33/Supplement_1

HYPERLIPIDEMIA

- Based on the National Heart, Lung and Blood Institute, Third Report on the Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III).
- Updated based on ATP III Update 2004: Implications of Recent Clinical Trials for the ATP III Guidelines
- Modifications to cholesterol clinical practice guideline are available at National Heart and Lung and Blood Institute Website, "Implications of Recent Clinical Trials for the National Cholesterol Education Program Adult Treatment Panel III Guidelines"
 - <http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3upd04.htm>

HYPERTENSION

- Based on the National Heart, Lung and Blood Institute of National Institutes of Health. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC-7).
- Access the NHLBI Guideline at: www.nhlbi.nih.gov/guidelines/hypertension/index.htm

Clinical Practice Guidelines

HEART FAILURE

- Based on the American College of Cardiology and the American Heart Association Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult.
- Access the ACC/AHA Guideline at: content.onlinejacc.org/cgi/reprint/46/6/e1

DEPRESSION

- Based on the Institute for Clinical Systems Improvement Guideline, Major Depression in Adults in Primary Care, May, 2009.
- Access the ICSI Guideline at: www.icsi.org . Select Health Care Guidelines By Title.

ADHD

- Based on the American Academy of Pediatrics Clinical Practice Guideline: Diagnosis and Evaluation of the Child with Attention- Deficit/Hyperactivity Disorder (Pediatrics Vol. 105 No. 5, May 2000).
- [Attention Deficit/Hyperactivity Disorder Practice Guidelines](#)

COPD

- Based on the Global Initiative for Chronic Obstructive Lung Disease (GOLD) COPD Diagnosis, Management, and Prevention.
- Access the [GOLD Pocket Guide to COPD Diagnosis, Management, and Prevention](#).

Non-Discrimination Notification

Molina Healthcare of Texas (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
 - Skilled sign language interpreters
 - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
 - Skilled interpreters
 - Written material translated in your language
 - Material that is simply written in plain language

If you need these services, contact Molina Member Services at (866) 449-6849 TTY/TTD: (800) 346-4128.

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY, 711. Mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (713) 623-0645.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can mail it to:

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

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

If you need help, call 1-800-368-1019; TTY 800-537-7697.

Non-Discrimination Notification

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-449-6849 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-449-6849 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-449-6849 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-449-6849 (TTY: 711)。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-449-6849 (TTY: 711) 번으로 전화해 주십시오.
Arabic	ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-449-6849 (رقم هاتف الصم والبكم: 711).
Urdu	نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت میں زبان کی مدد کی خدمات دستیاب ہیں۔ 1-866-449-6849 (TTY: 711) پر کال کریں۔
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-449-6849 (TTY: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-449-6849 (TTY : 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-449-6849 (TTY: 711) पर कॉल करें।
Persian (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-449-6849 تماس بگیرید. (TTY: 711)
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-449-6849 (TTY: 711).
Gujarati	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. કૃપા કરી 1-866-449-6849 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-449-6849 (телетайп: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-449-6849 (TTY: 711) まで、お電話にてご連絡ください。
Laotian	ປະຕິບັດ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທ 1-866-449-6849 (TTY: 711).