Medicaid

PROVIDER MANUAL

(Provider Handbook)

Molina Healthcare of Virginia, LLC

(Molina Healthcare or Molina)

Cardinal Care Managed Care

2023

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

Last Updated: March 2023

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Any reference to Molina Members means Molina Healthcare Members.

1. CONTACT INFORMATION

Mailing Address

Molina Healthcare
3829 Gaskins Road
Richmond, VA 23233

Provider Services Department

The Provider Services department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting and training. The department has Provider Services representatives who serve all of Molina's Provider network. Eligibility verifications can be conducted at your convenience via the Provider portal.

Phone	Cardinal Care Managed Care: (800) 424-4518
Fax	(888) 656-5098
Provider Portal	provider.MolinaHealthcare.com

Member Services Department

The Member Services department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, pharmacy inquiries, selecting or changing primary care Providers (PCP), and Member complaints. Member Services representatives are available 8 a.m. – 8 p.m. ET, Monday through Friday, excluding state holidays. Eligibility verifications can be conducted at your convenience via the Provider portal.

Phone	Cardinal Care Managed Care: (800) 424-4518
TTY/TDD	711

Claims Department

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

- Access the Provider Portal at provider.molinahealthcare.com
- EDI Payer ID MCC02

Any reference to Molina Members means Molina Healthcare Members.

To verify the status of your Claims, please use the Provider portal. For other Claims questions contact Provider Services.

Claims Recovery Department

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

Provider Disputes	Molina Healthcare of Virginia, Inc. 3829 Gaskins Road Richmond, VA 23233
Refund Checks Lockbox	Healthcare of Virginia, Inc. 401 Market Molina Street PO Box 780192 Philadelphia, PA 19178
Phone	(866) 642-8999

Compliance and Fraud Alert line

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

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889

Online: MolinaHealthcare.alertline.com

Credentialing Department

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

Molina Healthcare of Virginia, LLC

Attn: Credentialing Department
PO Box 2470
Spokane, WA 99210

Nurse Advice Line

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

Phone	24/7 Nurse Advice Line (833) 514-1809
TTY/TDD	711 Relay

Health Care Services Department

The Health Care Services (formerly Utilization Management) department conducts concurrent review on inpatient cases and processes prior authorizations/service requests. The Health Care Services (HCS) department also performs case management for Members who will benefit from case management services. Participating Providers are encouraged to interact with Molina's HCS department electronically whenever possible. Prior authorizations/service requests and status checks can be easily managed electronically.

Managing prior authorizations/service requests electronically provides many benefits to Providers, such as:

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

Molina offers the following electronic prior authorizations/service requests submission options:

- Submit requests directly to Molina via the Provider portal. See the Provider Portal Quick Reference Guide at provider.MolinaHealthcare.com or contact your Provider Services representative for registration and submission guidance

Provider Portal: provider.MolinaHealthcare.com

Phone: (800) 424-4518

Long Term Support Services	(800) 614-2116
Behavioral health	(855) 339-8179
Transplant	(877) 813-1206
Pharmacy and physician administered HCPCS	(844) 278-5731

Health Management

Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators along with access to educational materials.

Phone:

(866) 891-2320

Behavioral Health

Molina manages all components of Covered Services for behavioral health. For Member behavioral health needs, please contact us directly at:

Cardinal Care Managed Care (800) 424-4518

Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on the back of their Molina ID card.

Pharmacy Department

Prescription drugs are covered through CVS. A list of in-network pharmacies is available under the *Find a Doctor or Pharmacy tab* of the molinahealthcare.com website. You can also contact Molina at:

Phone:

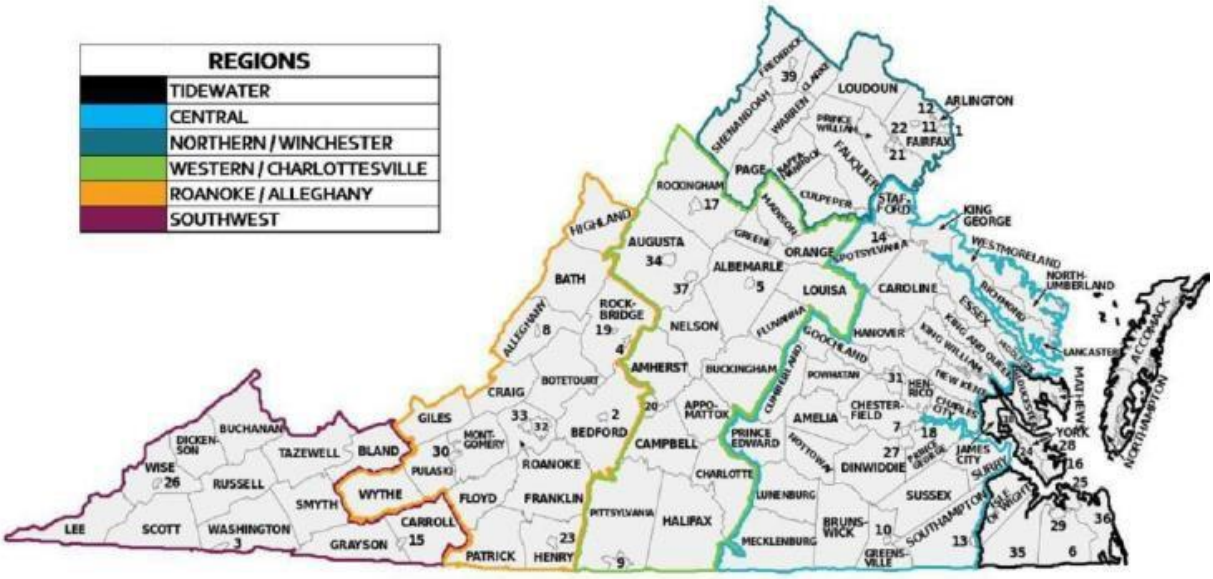
Cardinal Care Managed Care (800) 424-4518

Quality Improvement

Molina maintains a Quality Improvement department to work with Members and Providers in administering Molina's Quality programs.
Phone:

Cardinal Care Managed Care (800) 424-4518

Molina Healthcare of Virginia Service Area



Molina offers enrolment into its Molina Healthcare programs statewide in all six Department of Medical Assistance Services (DMAS) regions. A list of Molina regions by locality is available on the DMAS website: https://www.dmas.virginia.gov/#/index.

Cost Recovery Department Information

VIRGINIA (VA)		
Provider Disputes	**Refund Checks Lockbox**	**Fax Number**
Molina Healthcare of Virginia PO Box 2470 Spokane, WA 99210-2470	Molina Healthcare of Virginia, Inc. ATTN: Recoveries Lockbox 401 Market Street BOX 780192 Philadelphia, PA 19178-0192	(540) 645-6368

2. PROVIDER RESPONSIBILITIES

Non-Discrimination of Health Care Service Delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as outlined in the *Cultural competency and linguistic services* section of this Provider Manual.

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

Section 1557 Investigations

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

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

Toll Free: (866) 606-3889
TTY/TDD: 711
Online: MolinaHealthcare.AlertLine.com
Email: Civil.Rights@MolinaHealthcare.com

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

Facilities, Equipment and Personnel

The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider Data Accuracy and Validation

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

Maintaining an accurate and current Provider directory is a state and federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing and Encounter submission.

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) as soon as possible, but no less than 30 calendar days in advance of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition 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.

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

Please visit our Provider Online Directory (POD) at Sapphire365 to validate your information. For corrections and updates, a convenient Virginia Guide to Provider Forms can be found on the molinahealthcare.com website at MolinaHealthcare.com/providers/va/medicaid/resources/forms.aspx You can also notify your Provider Services representative if your information needs to be updated or corrected.

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

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

National Plan and Provider Enumeration System (NPPES) Data Verification

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

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

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

Molina Electronic Solutions Requirements

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

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

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the Provider portal.

Any Provider entering the network as a Contracted Provider will be encouraged to comply with Molina's electronic solution policy by enrolling for EFT/ERA payments, registering for the Provider portal within 30 days of entering the Molina network.

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

Electronic Solutions/Tools Available to Providers

Electronic solutions/tools available to Molina Providers include:

- Electronic Claims submission options
- Electronic payment: EFT with ERA
- Provider portal

Electronic Claims Submission Requirement

Molina strongly encourages Participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance.
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.).
- Increasing accuracy of data and efficient information delivery.
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminating mailing time 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 the Provider Portal Quick Reference Guide at 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 MCC02; refer to our website molinahealthcare.com for additional information.

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

Provider portal Claims submission includes the ability to:

- Add attachments to Claims.
- Submit corrected Claims.
- Easily and quickly void Claims.
- Check Claims status.
- Receive timely notification of a change in status for a particular Claim.
- Save incomplete/un-submitted Claims.
- Create/manage Claim templates.

For more information on EDI Claims submission, see the *Claims and compensation* section of this Provider Manual.

Electronic Payment Requirements

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 remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment, and

Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes.

Molina contracts with our payment vendor, Change Healthcare, who has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform you may receive your payment via EFT/ACH, a physical check, or a virtual card.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via Virtual Card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment and contacting ECHO Customer Service at (888) 834-3511 or medi@echohealthinc.com. Once your payment preference has been updated, all payments will go out in the method requested.

If you would like to opt-out of receiving a Virtual Card prior to your first payment, you may contact ECHO Customer Service at (888) 834-3511 or medi@echohealthinc.com and request that your Tax ID for payer Molina Healthcare of Virginia be opted out of Virtual Cards.

Once you have enrolled for electronic payments you will receive the associated ERAs from ECHO with the Molina Payer ID. Please ensure that your Practice Management System is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO provider portal (providerpayments.com.)

If you have any difficulty with the website or have additional questions, ECHO has a Customer Services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Customer Services team at (888) 834-3511.

As a reminder, Molina's Payer ID is MCC02.

Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper explanation of payment (EOP) (i.e., Remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download, and save historical and new ERAs with a two-year lookback.

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

Provider Portal

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

- Verify Member eligibility, Covered Services and view HEDIS needed services (gaps)
- Claims:
  - Submit professional (CMS1500) and institutional (CMS1450[UB04] Claims with attached files
  - Correct/void Claims
  - Add attachments to previously submitted Claims

    - Check Claims status
    - View electronic remittance advice (ERA) and explanation of payment (EOP)
    - Create and manage Claim templates
    - Create and submit a Claim appeal with attached files
- Prior authorizations/service requests
    - Create and submit prior authorizations/service requests
    - Check status of authorizations/service requests
- View HEDIS® scores and compare to national benchmarks
- View a roster of assigned Molina Members for Primary Care Providers (PCPs)
- Download forms and documents
- Send/receive secure messages to/from Molina

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts.

Member Rights and Responsibilities

Providers 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 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.

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

- Provider portal at provider.MolinaHealthcare.com
- Molina Provider Services automated IVR system at:

  Phone:

  Cardinal Care Managed Care: (800) 424-4518

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

Member Cost Share (Copayments and Patient Pay)

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

FAMIS Members are responsible for payment of nominal copayments for some services. The copayment amounts are determined based on the Member's household income, and Molina assigns collection of these copayments to the Providers. FAMIS Members have an annual maximum family copayment amount based on household income
Patient pay refers to an individual's obligation to pay towards the cost of LTSS if the Member's income exceeds certain thresholds. Patient pay is required to be calculated for every individual receiving LTSS and/or custodial care at a nursing facility or receiving waiver services, although not every eligible individual will end up having to pay each month. When a Member's income exceeds an allowable amount, the Member must contribute toward the cost of their LTSS. This contribution is known as the patient pay amount.

Additional information is available in the *Benefits and Covered Services* chapter of this Manual.

Health Care Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina's utilization management and care management programs, including all policies and procedures regarding Molina's facility admission, prior authorization, Medical Necessity review determination, and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of Covered Services.

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

In Office Laboratory Tests

Molina's policies allow only certain lab tests to be performed in a Provider's office regardless of the line of business. All other lab testing must be referred to an in-network laboratory Provider

that is a certified, full-service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found on the Molina website at molinahealthcare.com.

Additional information regarding in-network laboratory Providers and in-network laboratory Provider patient service centers is found on the laboratory Providers' respective websites at appointment.questdiagnostics.com/patient/confirmation and labcorp.com/labs-and-appointments.

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

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

Referrals

A referral may become necessary when a Provider determines Medically Necessary services are beyond the scope of the PCP's practice, or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care and hospital emergency room. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Molina except in the case of Emergency Services.

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

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to Molina.

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 as applicable.
- Delivery of patient care information.

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

Compliance

Providers must comply with all state and federal Laws and regulations related to the care and management of Molina Members.

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member protected health information.

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

Participation In Grievance and Appeals Programs

Providers are required to participate in Molina's grievance program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than 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 process* section of this Provider Manual.

Participation in Credentialing

Providers are required to participate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable accreditation, state and federal requirements. This includes providing prompt responses to Molina's requests for information related to the credentialing or re-credentialing process.

Providers must notify Molina no less than 30 days in advance when they relocate or open an additional office.

More information about Molina's credentialing program, including policies and procedures is available in the *Credentialing and Recredentialing* section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegation Policies and Delegated Services Addendum. Please see the *Delegation* section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

Primary Care Provider Responsibilities

PCPs are responsible to:

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

3. CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages, and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at molinahealthcare.com, from your local Provider Services representative and by calling Molina Provider Services at:

Cardinal Care Managed Care (800) 424-4518

Non-Discrimination Of Health Care Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website 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), the Office for Civil Rights (OCR), state Law, and federal program rules which prohibit discrimination. Providers must post a non-discrimination notification in a conspicuous location in their office along with translated non-English taglines in the top 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. For additional information, please refer to the Member handbook located at molinahealthcare.com.

Additionally, Participating Providers or contracted medical groups may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

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

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

Members can mail their complaint to Molina at:

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

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

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

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

If you or a Molina Member needs help, call (800) 368-1019 (TTY/TDD: 800-537-7697).

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

Cultural Competency

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

Provider and Community Training

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

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

1. Provider written communications and resource materials.
2. On-site cultural competency training.
3. Online cultural competency Provider training modules.
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications.

Integrated Quality Improvement – Ensuring Access

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

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

Key Member information, including appeal and grievance forms, is also available in threshold languages on the Molina Member website.

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership
  - Contracted Providers to assess gaps in network demographics
- Revalidate data at least annually
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report)
- Applicable national demographics and trends derived from publicly available sources

- Assessment of Provider Network
- Collection of data and reporting for the Diversity of Membership HEDIS® measure
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at:

Cardinal Care Managed Care (800) 424-4518

Contact Center representatives will connect you and the Member to a qualified language service provider.

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or minor to interpret.

Documentation

As a contracted Molina Provider, your responsibilities for documenting Member language services/needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by Molina
- Document all Member requests for interpreter services
- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor
- Document all counseling and treatment done using interpreter services
- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of their right to have a qualified interpreter at no cost

Members Who are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member Services, quality, health care services and all other health plan functions.

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

Molina will provide face-to-face service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made three business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via Molina Member Services.

Nurse Advice Line

Molina provides nurse advice services for Members 24 hours per day, seven days per week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly:

Nurse Advice Line (833) 541-1809

TTY/TDD: 711

The Nurse Advice Line telephone numbers are also printed on membership cards.

4. MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member handbook and on the Molina website. The Member handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member rights and responsibilities can be accessed via the following link: MolinaHealthcare.com/members/va/en-us/mem/medicaid/quality/rights.aspx

Member handbooks are available on Molina's Member website. Member rights and responsibilities are outlined under the "Member Rights" and "Member Responsibilities" chapters within the Member handbook documents.

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

For additional information, please contact Molina at:

Cardinal Care Managed Care (800) 424-4518

TTY/TDD: 711

Second Opinions

If Members do not agree with their Provider's plan of care, they have the right to a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require prior authorization.

5. ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

Enrollment

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

Cardinal Care Managed Care

Cardinal Care includes Medicaid Members who:

- Receive Medicare benefits and full Medicaid benefits (dual eligible).
- Receive Medicaid long-term services and supports (LTSS) in a facility or through one of the home- and community-based (HCBS 1915(c)) waivers.
- Are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups, including ABD Members previously enrolled in the Cardinal Care Managed Care program.

Members enrolled in the Developmental Disabilities Support (DD) waiver will be enrolled in Cardinal Care for their non-waiver services only, and their waiver services will continue to be covered through Medicaid fee-for-service.

DMAS reserves the right to transition additional populations and services into the Cardinal Care program in the future. When this occurs, DMAS will notify the Managed Care Organizations (MCOs) and this manual will be revised.

Cardinal Care Managed Care Waiver

Enrollment in Cardinal Care Waiver is mandatory for eligible Members to receive waiver services. DMAS has sole authority and responsibility for enrollment into the MLTSS program.

Regardless of age, the request for enrollment in the Cardinal Care Waiver originates from four different possible sources: acute care hospitals, nursing facilities, the local department of social services (LDSS), or the local health department (LHD) in the locality where the Member resides. All Members must be Medicaid eligible and have a Virginia Universal Assessment Instrument (UAI) completed by their local preadmission screening team (which consists of a representative from the LDSS and the LHD) within their community, or by an acute care hospital discharge planner if the Member is hospitalized. There is no cost to be screened to determine eligibility for the Cardinal Care Waiver. There may be a patient pay required for services based on the Member's earned and unearned income. The LDSS eligibility worker will determine if a Member has a patient pay responsibility.

Based on the results of the UAI and financial review, DMAS determines if the Member meets eligibility criteria for the subpopulations mentioned above. DMAS notifies the Managed Care Organizations (MCOs) via a weekly eligibility file of enrollment into Cardinal Care, and the subpopulation for which the Member is enrolled.

The Member may request to change MCOs within 90 days after the initial enrollment effective date into Cardinal Care. After the initial 90 days, the Member may not disenroll without cause until the next open enrollment period.

Upon enrollment, Molina will conduct an initial Health Risk Assessment (HRA) to determine the Member's needs and complete an Initial Individualized Care Plan (ICP) which includes, but is not limited to, the Member's expressed goals, services the Member needs and will receive (regardless of payer source), and the Member's preferences for their care and Provider selection.

Upon enrollment, each Cardinal Care Member receives a Molina Member ID card reflecting his/her PCP name and effective date. The Member Services number for Molina is located on the back of the ID card.

Cardinal Care Managed Care

Cardinal Care membership includes the following:

- Low Income Families with Children (LIFC).
    - Adults—parents and other caretaker relatives of dependent children with household income at or below a standard established by the state
    - Children and infants—children and infants younger than 19 with household income at or below standards based on this age group
    - Pregnant women—women who are pregnant or postpartum with household income at or below a standard determined by the state
    - Note: children qualifying under this eligibility group meet the following criteria:
        - They are younger than age 19

- They have a household income at or below the standard established by the state

- Children and Youth with Special Health Care Needs (CYSHCN)—children and youth with special health care needs that have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age.
    - Early intervention—services designed to meet the developmental needs of children and families and to enhance the development of children from birth to the day before the third birthday who have:
        - A 25% developmental delay in one or more areas of development,
        - Atypical development, or
        - A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
    - Children in foster care—children who have been temporarily or permanently displaced from their birth parents and are in the custody of the state.
    - Substance exposed infants, including infants with Neonatal Abstinence Syndrome.
    - Newborns.
    - Individuals covered under Medicaid Expansion.
    - Those eligible for Family Access to Medical Insurance Security (FAMIS).
        - FAMIS (Title XXI CHIP program)—CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. FAMIS Members are assigned a copay level ($2/$5) based on the guidance provided by DMAS. Regularly validate the Member's eligibility to ensure the accurate copayment amount is collected at the time services are rendered.
        - FAMIS MOMS—uninsured pregnant females, not eligible for Medicaid with family income at or below 200% of the federal poverty level (plus a 5% disregard). Covered Services for FAMIS.

DMAS retains sole responsibility for determining Member eligibility for Cardinal Care programs and services. DMAS also retains sole responsibility for determining enrollment with Molina. Molina has agreed to enroll and provide coverage for Members as determined by DMAS.

Upon DMAS transmittal of the 834 Enrollment File, Molina immediately loads the file into the eligibility source system and provides coverage immediately to Members as indicated by the enrollment start date of coverage for the applicable Members.

Eligibility Verification

Medicaid programs

The state of Virginia, through DMAS, determines eligibility for the Medicaid programs, including Cardinal Care. 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.

Eligibility listing for Medicaid programs

Providers who contract with Molina may verify a Member's eligibility and/or confirm PCP assignment by checking the following:

- Provider portal at provider.MolinaHealthcare.com
- Molina Provider Services automated IVR system at:

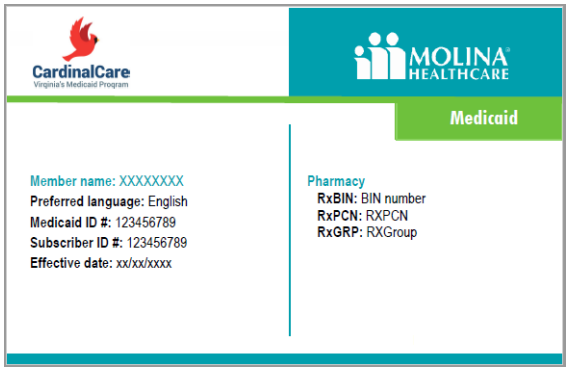
Cardinal Care Managed Care: (800) 424-4518

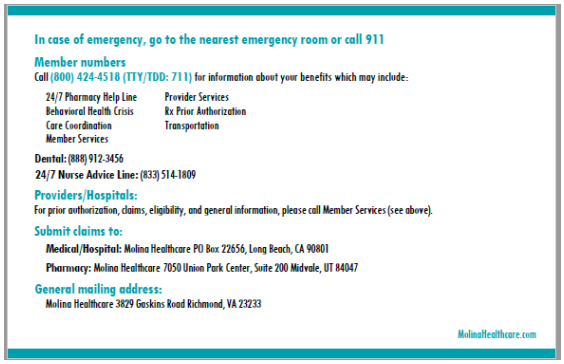
Possession of a Molina ID Card does not mean a recipient is eligible for Medicaid services. A Provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

Identification Cards

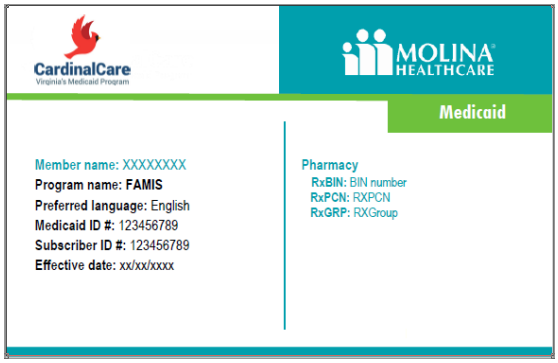
Molina Sample Member ID cards

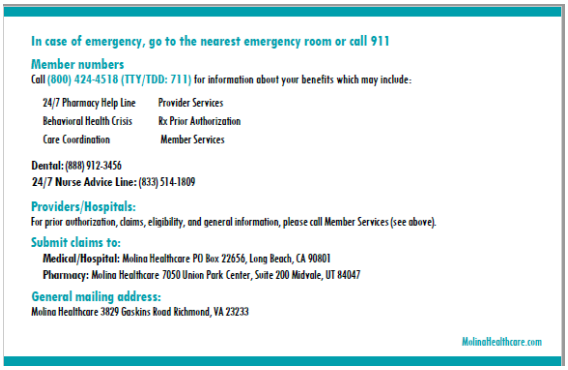
Medicaid





FAMIS





Any reference to Molina Members means Molina Healthcare Members.

Members are reminded in their Member handbooks to present ID cards when requesting medical or pharmacy services. The Molina ID card can be a physical ID card or a digital ID card. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment, prior to rendering services.

Disenrollment

Cardinal Care disenrollment from Molina with cause

A Member may request to change MCOs within 90 days after the initial enrollment effective date into the Cardinal Care program, without cause. After the initial 90 days, the Member may not disenroll without cause until the next open enrollment period.

Below are the reasons Members may request disenrollment from their current MCO at any time. A Member may be disenrolled from their current MCO only when authorized by DMAS.

- The Member moves out of the MCO's service area
- The Member needs related services to be performed at the same time, not all related services are available within the MCO's network, and the Member's PCP or other Provider determines that receiving the services separately would cause unnecessary risk for the Member
- The Member who receives LTSS would have to change their residential, institutional, or employment supports based on that Provider's change in status from an in-network to an out-of-network Provider with the MCO and, as a result, would experience a disruption in their residence or employment
- Other reasons as determined by DMAS, including poor quality of care, lack of access to Covered Services, or lack of access to Providers experienced in dealing with the Member's care needs

Voluntary disenrollment does not preclude Members from filing a grievance with Molina for incidents occurring during the time they were covered.

Voluntary disenrollment from Cardinal Care Waiver

A Member may request to voluntarily disenroll from the LTSS waiver for any reason. The request must be made by the Member directly to their assigned Care Manager. The Care Manager will educate the Member the ramifications of losing the waiver and that if they should change their mind and desire to have waiver services reinstated, they would need to be rescreened and found eligible for the LTSS waiver again.

The Care Manager would then complete the required notification to DMAS noting the Member's choice to terminate waiver services. DMAS will be responsible for termination of waiver services and updating the Member's eligibility (as appropriate) based on this decision and will then notify the MCO.

Voluntary disenrollment does not preclude Members from filing a grievance with Molina for incidents occurring during the time they were covered.

Involuntary disenrollment from Cardinal Care

A Member's enrollment in the Cardinal Care program will end upon the occurrence of any of the following events:

- Death of the Member
- Cessation of Medicaid eligibility
- The Member meets at least one of the exclusion criteria as determined by DMAS
- Transfer to a Medicaid eligibility category not included in the Cardinal Care Managed Care program
- Certain changes made within the Medicaid Management Information System (MMIS) by eligibility case workers at the Department of Social Services

Molina notifies DMAS in the event it becomes aware of circumstances that might affect a Member's eligibility or whether there has been a status change such that a Member would be disenrolled from Molina.

In addition to the reasons above, there may be other appropriate reasons for involuntary disenrollment from LTSS. Those reasons may include, but are not limited to, the following related to program participation:

- Molina has determined (and DMAS has reviewed and concurs) that the Member's needs can no longer be safely met in the community and the Member has declined nursing facility placement
- Molina has determined (and DMAS has reviewed and concurs) that the Member's needs can no longer be safely met in the community, and at a cost that does not exceed the cost of nursing facility care for which the Member would qualify
- The Member no longer meets the qualifications for LTSS services (and DMAS has reviewed and concurs) or the Member is no longer receiving LTSS

LTSS may continue throughout the involuntary disenrollment and appeal process(es) until final determination by DMAS is received. In the event of an appeal, ongoing monitoring is conducted to evaluate for change in the circumstances contributing to the disenrollment.

Although Molina may not request disenrollment of a Member, we will inform DMAS promptly when we have reason to believe that a Member may satisfy any of the conditions for disenrollment from the Cardinal Care Managed Care program as described above.

Molina is responsible for the disenrolling Member until the disenrollment is processed by DMAS and will provide Medically Necessary Covered Services through the Member's disenrollment

date.

Molina will be notified of the Member's disenrollment via the 834 Enrollment File from DMAS

PCP Assignment

PCP assignment for non-dual eligible Members

Molina assigns all non-dual Members to a PCP at the date of enrollment. Members may select a different PCP at any time if they choose. When we call the Member to schedule an initial assessment, we offer the Member the opportunity to change their PCP assignment. We can assist Members in finding new PCPs.

Our experience shows that Members often require highly specialized primary care services to address their complex needs, along with MLTSS services and supports. Our approach to PCP assignment links Members to the PCP best suited to meet their needs, including allowing a specialist to serve as PCP if necessary. We prioritize PCP assignment with Federally Qualified Health Centers and Community Service Boards as available and appropriate so Members can receive primary care services at a location that best meets their needs.

PCP assignment for dual eligible Members

For dual eligible Members, a PCP is not assigned, Molina utilizes all DMAS and Medicare information provided to identify the Member's Medicare PCP and enhance our care coordination efforts. We assist the Member in finding or changing a PCP, including contacting the individual's Medicare health plan care manager when necessary.

We work with PCPs to coordinate care and invite the individual to participate in ICTs. We inform dual eligible Members about their right to access Medicare Providers, regardless of whether the Provider is in our network, and without having to obtain prior approval.

PCP Changes

The PCP relationship is critical to our Members, and Molina will assign a PCP to most Members upon enrollment. Members are free to see any PCP within our network. Providers should encourage their Members to contact Molina Member Services to update their PCP:

Cardinal Care Managed Care: (800) 424-4518 (TTY: 711)

PCP change requests made prior to the 15th of the month are retroactive to the first day of the month in which the change was requested. Change requests made on or after the 15th of the month are effective on the first day of the next month.

6. BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and Covered Services for Cardinal Care Managed Care Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires prior authorization. please reference the prior authorization tools located at on the Molina website and the Provider portal. You may also please contact Molina at:

Cardinal Care Managed Care: (800) 424-4518

Copayments and Patient Pay

FAMIS Members are responsible for payment of nominal copayments for some services. The copayment amounts are determined based on the Member's household income, and Molina assigns collection of these copayments to the Providers.

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

FAMIS Members have an annual maximum family copayment amount based on household income.

Should FAMIS Members reach their maximum family copayment amount after Claims are processed, Claims may require retroactive adjustment to reflect the accurate copayment amounts (DMAS-225 Form).

Patient Pay

Patient pay refers to an individual's obligation to pay towards the cost of LTSS if the Member's income exceeds certain thresholds. Patient pay is required to be calculated for every individual receiving LTSS and/or custodial care at a nursing facility or receiving waiver services, although not every eligible individual will end up having to pay each month. When a Member's income exceeds an allowable amount, the Member must contribute toward the cost of their LTSS. This contribution is known as the patient pay amount.

DMAS will provide information to Molina identifying Members who are required to pay a patient pay amount and the amount of the obligation as part of its monthly transition report. Molina will work with its Providers to ensure understanding of its policies and procedures to ensure exchange of information including collection of the patient pay amounts.

Molina is required to establish a process to ensure collection of the patient pay amounts by the appropriate Providers. We shall reduce reimbursements to LTSS Providers equal to the patient pay amounts each month. We use DMAS' method for assigning patient pay collection to LTSS Providers unless an alternate methodology is approved by DMAS. Refer to DMAS manuals for DMAS's process on patient pay.

The Medicaid LTC Communication Form (DMAS-225) is used by the local Department of Social Services to inform LTSS Providers of Medicaid eligibility and to exchange information. We will coordinate with the Provider and office staff to ensure that a completed DMAS-225 is in the record of each Member receiving nursing facility or waiver services.

Please refer to the September 2015 DMAS Medicaid Memo for additional information regarding

DMAS's process on patient pay.

Services Covered by Molina

Molina covers the services described in the Summary of Benefits documentation. If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools located at on the Molina website and the Provider portal. You may also contact Molina at:

Cardinal Care Managed Care: (800) 424-4518

Link(S) To Benefit Information

The following web link provides access to a summary of the benefit information for the Cardinal Care Managed Care programs offered by Molina in Virginia:

https://www.molinahealthcare.com/members/va/en-us/mem/medicaid/benefits-and-services.aspx

Obtaining Access to Certain Covered Services

Non-preferred drug exception request process

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

- For a standard exception request, the Member and/or Member's representative and the prescribing Provider will be notified of Molina's decision within 24 hours of receiving the complete request.
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within 24 hours of receiving the complete request.
- Members will also have the right to appeal a denial decision, per any requirements set forth by DMAS.
- Molina will allow a 72-hour emergency supply of prescribed medication for dispensing at any time that a prior authorization is not available. Pharmacists will use their professional judgment regarding whether or not there is an immediate need every time

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

Specialty drug services

Many self-administered and office-administered injectable products require prior authorization. In some cases, they will be made available through a vendor, designated by Molina. More information about our prior authorization process, including a link to the prior authorization request form, is available in the *Health Care Services* section of this manual. Physician administered drugs require the appropriate 11-digit NDC with the exception of vaccinations or other drugs as specified by CMS.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered at no cost.

Injectable and infusion services

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

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

Access to behavioral health services

Members can access behavioral health services through PCP referral, or Members can self-refer by calling Molina's Behavioral Health department at:

Cardinal Care Managed Care: (800) 424-4518

Molina's Nurse Advice Line is available 24 hours a day, seven days a week at (833) 514-1809 for mental health or substance abuse needs. The services Members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained in the benefit information linked above, or by contacting Molina. If inpatient services are needed, prior authorization must be obtained, unless the admission is due to an emergency situation.

Emergency mental health or substance abuse services

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

- Being a danger to oneself or others.
- Not being able to carry out daily activities.
- Things that will likely cause death or serious bodily harm.

Out-of-area emergencies

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

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

For out-of-area Emergency Services, out-of-network Providers are directed to call the Molina contact number on the back of the Member's ID card for additional benefit information and may be asked to transfer Members to an in-network facility when the Member is stable.

Emergency transportation

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

Non-emergency medical transportation

Introducing Veyo: Our vendor for non-emergency medical transportation

Molina has partnered with Veyo for non-emergency medical transportation (NEMT) services for our Members. Molina knows Members need reliable transportation to access care in their communities. Veyo utilizes various technologies to enhance coordination of Member transportation. Veyo provides reliable, punctual transportation services and exceptional customer service for our Members. Veyo is responsible for:

- Taking reservations from Members, healthcare facilities, medical Providers, caregivers and caseworkers for NEMT trips.
- Contracting with third-party transportation Providers.
- Providing payment for NEMT Claims.

Is there a cost to Members for transportation services?

- Transportation to eligible appointments/services is a covered benefit for Molina Members.
- Members receive the transportation benefit at no cost.

What should you know before booking a trip for a Member?

- The Member must be enrolled in Medicaid and must be a Molina Member. They must be attending a Covered Service and have no other means of transportation. NEMT is

offered to Members who cannot drive themselves and/or do not have a neighbor, friend, relative or voluntary organization that can transport them to a covered appointment.

- The Member (or Provider acting on behalf of the Member) must request transportation a minimum of three business days (72 hours) in advance.
- Members should be ready for pickup one hour before their appointment time.

What types of transportation services are available through Veyo?

- Mileage reimbursement
- Public transit (bus passes)
- Ambulatory (standard car/van)
- Wheelchair van
- Stretcher van
- Bariatric stretcher and wheelchair
- Ambulance–Basic Life Support (BLS) and Advanced Life Support (ALS)

How do I schedule a ride for a Member?

To request transportation on behalf of a Molina Member, please call Veyo at (877) 790-9472 for Cardinal Care Managed Care Members. *

Please call to schedule at least three business days (72 hours) before the Member's healthcare appointment. If you call within 72 hours of the appointment and the trip is not urgent, the Member may need to set up their visit for a different date. The call center's hours of operation are 8 a.m. to 8 p.m. local time, Monday through Friday. During non-operating hours, representatives are available for assistance with hospital discharges and other covered urgent trips.

When scheduling the trip, please keep in mind that the driver may drop off the Member at your facility at the scheduled appointment time. If it is a large facility or the Member needs to arrive before the appointment time, please factor this in when scheduling transportation. How do I cancel a scheduled trip for a Member?

To cancel a scheduled trip for a Molina Member, please call Veyo at (877) 790-9472 for Cardinal Care Managed Care members. *

Please let Veyo know as soon as the Member cancels his or her appointment with you. Please communicate with the Member to let them know that you have cancelled their trip reservation.

Veyo will cancel the scheduled trip and notify the assigned transportation service Provider that the trip will no longer be occurring.

How do I schedule a recurring trip for a Member?

A recurring trip is a trip to the same location more than once per week, for more than two weeks. Recurring trips for Molina Members can be scheduled by calling Veyo at (877) 790-9472 for Cardinal Care Managed Care Members. *

When will a Member need Molina's prior authorization for booking trips?

- For any one-way trip that is over 50 miles
- For recurring or "blanket" trips, meaning more than once per week, for more than two weeks to the same location. Blanket trip authorizations for transport to dialysis services will be valid for six months. Blanket trip authorizations for transport to non-dialysis services will be valid for three months

How can a Member, or Provider working with a Member, request prior authorization?

Transportation should be scheduled with Veyo using the standard process. Veyo will then submit any trips requiring prior authorization to Molina for review. For questions regarding prior authorizations, please call Molina Member Services toll free at (800) 424-4518 (TTY 711) for Cardinal Care Managed Care Members.

What time should I use when requesting transportation for a Member?

Please use the actual time the Member needs to arrive at the facility. Do not use appointment time. For the return ride, please use the actual time the Member will be ready to leave the facility. If the return time is not known at the time of the reservation, Veyo will assign the return trip as a will-call trip. Please call Veyo to request a return trip pick up at (877) 790-9472 for Cardinal Care Managed Care Members or (833) 273-7416.

A transportation Provider will arrive within 45 minutes following a will-call request.

Who do I call to get an estimated time of arrival for a Member's transportation?

Please call Veyo at (877) 790-9472 for Cardinal Care Managed Care (833) 273-7416 Members and then follow the prompts.

What should I do if a Member does not arrive for their scheduled appointment?

First, call the Member to verify that he or she did not cancel transportation or their appointment. If the Member did not cancel the transportation, please check on the status by calling Veyo at (877) 790-9472 for Cardinal Care Managed Care Members r (833) 273-7416 . *

If you are unable to reach the Member, please call the appropriate number above to resolve the issue.

Are there requirements and standards in place for transportation Providers to promote safe, high quality services?

Prior to providing transportation services to any Member, all of Veyo's drivers go through

extensive onboarding which includes, but is not limited to:

- ADA and HIPAA regulation training.
- Sensitivity and professionalism training.
- Customer service expectations.
- Compliance with Veyo protocols and contractual obligations.
- CPR and first aid certification.
- State Level 1 background check.
- Rigorous vehicle inspection.

What happens if there is an emergency weather event?

Veyo monitors all weather conditions when scheduling and accommodating trips. If the conditions are not safe for travel, the Member will receive a call to reschedule his or her appointment. The Member should then inform you of the cancellation. All passengers who have been taken to an appointment will be picked up and taken home.

Where can I find more information about Veyo and transportation?

Please visit Veyo's website at veyo.com. Mileage reimbursement information is available at va.mccmileage.com.

How do Members file a complaint?

To file a complaint, a Member can contact Veyo at (877) 790-9472 for Cardinal Care Managed Care Members (833) 273-7416 . *

** Call Molina Member Services for help with any of the above services at (800) 424-4518 (TTY 711) for Cardinal Care Managed Care Members.*

Preventive care

Preventive Care Guidelines are located on the Molina website at https://www.molinahealthcare.com/providers/va/medicaid/health/prevent.aspx.

We need your help conducting these regular exams to meet the targeted state and federal standards. If you have questions related to well child care, please call our Health Care Services team at:

Cardinal Care Managed Care (800) 424-4518

To promote self-care and personal responsibility, we offer Member incentive programs that reward Members for activities such as completing a preventive visit or health risk assessment. By participating in these healthy behaviors, Members can earn rewards in the form of gift cards for their personal use. To learn more, visit molinahealthcare.com.

Immunizations

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

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

Molina covers immunizations not covered through Vaccines for Children (VFC).

Well child visits and EPSDT guidelines

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

The screening services include:

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

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

We need your help conducting these regular exams in order to meet the DMAS targeted standard. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well child care, please call (800) 424-4518.

Newborn hearing screenings

Molina requires all newborns to receive a hearing screening from an audiologist per EPSDT Global Coverage Guidelines. All screenings must be completed prior to hospital discharge after birth, unless appropriate communication has been provided to us. Follow-up visits should be scheduled if necessary, based on the results of the screening.
The appropriate written documentation of service (or referral if necessary) must be placed in the recipient's medical record within 24 hours after the Provider completes the screening procedure or within 24 hours of the parent's or guardian's signed refusal of screening. This information should be provided directly to the PCP as the coordinator of care. The documentation must include the following:

- Type of screening test administered, date of test, and tester's name
- Results
- Interpretation
- Recommendations
- Follow-up referrals for treatment, if applicable
- Parent's or guardian's refusal of screening, if applicable

Prenatal care

Molina's maternal health program offers comprehensive, ongoing education and support to all pregnant Members from identification through the postpartum period.

This program is built to optimize care and outcomes for our pregnant Members and their newborns by engaging Members, partnering with Providers, and integrating community resources and nontraditional services into local health systems. Our model of care builds an infrastructure within the health system which supports and enhances the relationship between Members and their Providers. We use every means available to identify, engage and support our pregnant Members and connect them to care to achieve the best possible outcome for the Member and the newborn. Our program empowers Members with actionable health information and tools that inform, enable, influence and incentivize Member engagement in

self-management. We offer culturally sensitive, individualized interventions designed to help the pregnant Member and the baby remain healthy.

Our maternal health program is designed to:

- Optimize the health of our pregnant Members.
- Promote the delivery of a healthy, full-term infant.
- Lower overall health care costs related to pregnancy and newborn care.

The table below provides the expected prenatal visit schedule, based on the American College of Obstetricians and Gynecologists recommendations.

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

Emergency Services

Emergency Services are covered inpatient and outpatient services that are (1) rendered by participating or non-participating Providers qualified to furnish these services and (2) needed to evaluate or stabilize an Emergency Medical Condition pursuant to 42 CFR §438.114.

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

Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week, 365 days a year, to assess symptoms and help make good health care decisions.

Molina is committed to helping our Members:

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

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

Health Management Programs

Health management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members.

Health education/disease management

Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators along with access to educational materials. You can refer Members who may

benefit from the additional education and support Molina offers. Members can request to be enrolled or disenrolled in these programs at any time. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Heart failure
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Obesity
- Oncology
- Weight management
- Smoking cessation
- Serious Mental Illness (SMI) and substance use disorder
- Maternity Screening and high-risk obstetrics

For more information about these programs, please call (800) 424-4518.

Telehealth And Telemedicine Services

Molina Members may obtain Covered Services by Participating Providers through the use of telehealth and telemedicine services. Not all Participating Providers offer these services. The following additional provisions apply to the use of telehealth and telemedicine services:

- Services must be obtained from a Participating Provider
- Services are meant to be used when care is needed now for non-emergency medical issues
- Services are a method of accessing covered services, and not a separate benefit
- Services are not permitted when the Member and Participating Provider are in the same physical location
- Services do not include texting, facsimile or email
- Services include preventive and/or other routine or consultative visits during a pandemic
- Member copayments associates to the Schedule of Benefits based upon the Participating Provider's designation for Covered Services (i.e., primary care, specialist or other practitioner)
- Covered Services provided through store-and-forward technology, must include an in-person office visit to determine diagnosis or treatment

Upon at least 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. Providers shall make their personnel reasonably available to answer questions from Molina regarding telehealth

operations.

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

7. HEALTH CARE SERVICES

Introduction

Health Care Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina utilization management program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, Medical Necessity review, and restrictions on the use of out-of-network Providers.

Utilization Management (UM)

Molina ensures the service delivered is Medically Necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care as well as integrating a range of services appropriate to meet individual needs. Molina maintains flexibility to adapt to changes in the Member's condition and is designed to influence Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care.
- Evaluating the Medical Necessity and efficiency of health care services across the continuum of care.
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs.
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization.
- Implementing comprehensive processes to monitor and control the utilization of health care resources.
- Ensuring services are available in a timely manner, in appropriate settings, and are planned, individualized and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring qualified health care professionals perform all components of the UM processes.
- Ensuring that UM decision making tools are appropriately applied in determining Medical

Necessity decision.

Key functions of the UM program

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

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	Discharge Planning and Care Transitions	Monitor for possible over- or under-utilization of clinical resources
Verifying of current physician/hospital contract status	Staff education on consistent application of UM criteria	Quality oversight
		Monitor for adherence to CMS, NCQA, state and health plan UM standards

This Molina Provider Manual contains excerpts from Molina's Health Care Services program description. For more information about Molina's UM program, or to obtain a copy of the HCS program description, clinical criteria used for decision making, and how to contact a UM reviewer, access the Molina website or contact the UM department.

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

UM decisions

A UM decision is any determination made by Molina or the delegated medical group or other delegated entity with respect to:

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to delay, modify, or deny payment of request (adverse determination);
- Discontinuation of a payment for a service;
- Payment for temporarily out-of-the-area renal dialysis services; and,
- Payment for post stabilization care or urgently needed services.

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

Board certified licensed Providers from appropriate specialty areas are utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with federal regulatory requirements and NCQA standards.

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

Providers can contact Molina's Health Care Services department to obtain UM criteria at: (800) 424-4518.

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

Medical necessity

"**Medically Necessary**" or "**Medical Necessity**" per Virginia Medicaid, is an item or service provided for the diagnosis or treatment of an enrollee's condition consistent with the standards of medical practice and in accordance with Virginia Medicaid policy (12VAC 30-130-600) and EPSDT criteria (for qualifying Members under age 21) and federal regulations as defined in 42CFS § 438.210 and 42 CFR § 440.230.

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.
3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This

literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/benefit.

MCG Cite for Guideline Transparency

Molina has partnered with MCG Health to implement Cite for Guideline Transparency.

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

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

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

Medical necessity review

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

Levels of administrative and clinical review

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

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

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

Clinical information

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

Prior authorization

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

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

- Member demographic information (name, date of birth, Molina ID number)
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number)
- Member diagnosis and ICD-10 codes
- Requested service/procedure, including all appropriate CPT and HCPCS codes
- Location where service will be performed
- Clinical information sufficient to document the Medical Necessity of the requested service is required including:
    - Pertinent medical history (include treatment, diagnostic tests, examination data)
    - Requested length of stay (for inpatient requests)
    - Rationale for expedited processing

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon Medical Necessity and Member eligibility at the time of service. Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions,

beneficiary eligibility on the Date of Service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care. Molina does not retroactively authorize services that require PA.

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 Member, the health or safety of the Member or others, due to the

Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited organization determinations/pre-service authorization request, Molina will make a determination as promptly as the Member's health requires and no later than contractual requirements or 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 no later than contractual requirements.

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss Medical Necessity decisions with the requesting Provider at (800) 424-4518.

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

Peer-to-peer

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five business days of the decision for prior authorization requests. For inpatient admissions, a request for a peer-to-peer discussion may be granted within five business days from discharge.

A "peer" is considered a physician, physician assistant, nurse practitioner, or PhD psychologist who is directly providing care to the Member or a Medical Director on site at the facility. Calls

from EHR and other similar contracted external parties, administrators, or facility UM staff are not peers and calls will not be returned.

Requesting prior authorization

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

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the molinahealthcare.com website:

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

The most current Prior Authorization Guidelines and the prior authorization request form can be found on the Molina website at molinahealthcare.com.

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

- Create and submit prior authorization requests
- Check status of authorization requests
- Receive notification of change in status of authorization requests
- Attach medical documentation required for timely medical review and decision making

Fax: The Prior Authorization Request Form can be faxed to Molina at:

Advanced images	(877) 731-7218
Inpatient physical health	(866) 210-1523
Outpatient physical health	(855) 769-2116
Long Term Support Services	(800) 614-2116
Behavioral health	(855) 339-8179
Transplant	(877) 813-1206
Pharmacy and physician administered HCPCS	(844) 278-5731

Phone: Prior authorizations can be initiated by contacting Molina's Health Care Services department at (800) 424-4518.

It may be necessary to submit additional documentation before the authorization can be processed.

Open communication about treatment

Molina prohibits contracted Providers from limiting Provider or Member communication

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

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

Delegated utilization management functions

Molina may delegate UM functions to qualifying medical groups 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 (800) 424-4518.

Staff are available during normal business hours, Monday through Friday (except for holidays) from 8 a.m. to 6 p.m. ET. 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 24 hours a day, seven days a week at (833) 514-1809.

Emergency Services

Emergency Services are covered inpatient and outpatient services that are (1) rendered by participating or non-participating Providers qualified to furnish these services and (2) needed to evaluate or stabilize an Emergency Medical Condition pursuant to 42 CFR §438.114.

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

Emergency Medical Condition or Emergency means: Per Virginia Medicaid, an item or service provided for the diagnosis or treatment of an enrollee's condition consistent with standards or medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for those under age 21), and federal regulations as defined in 42 CFR §438.210 and 42 CFR §440.230.

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

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

Molina also provides Members a 24-hour Nurse Advice Line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: Molina contracts with vendors that provide 24-hour Emergency Services for ambulance and hospitals. An out of network emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a participating facility. Services provided after stabilization in a non-participating facility are not covered and the Member will be responsible for payment.

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

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

Inpatient management Elective inpatient admissions

Molina requires prior authorization for all elective/scheduled inpatient admissions and procedures to any facility. Facilities are required to also notify Molina within 24 hours or by the following business day once the admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent inpatient admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of

admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, Medical Necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay.

Inpatient at time of termination of coverage

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

Inpatient/concurrent review

Molina performs concurrent inpatient review to ensure Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans.

Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within 24 hours of the request.

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

Molina will authorize hospital care as an 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 Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient status determinations

Molina's UM staff follow CMS and state specific 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* section of this manual).

Discharge planning

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

Molina staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review Medical Necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is an important part of Molina's Quality Improvement program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.

Molina will conduct readmission reviews when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

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

When a subsequent admission to the same facility occurs within 30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then the payment for such cases shall be paid at 50 percent of the normal rate. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three digits.

- Readmissions that are excluded from consideration as preventable readmissions include:
  - Planned readmissions
  - Neonatal and obstetrical readmissions

- Initial admissions with a discharge status of “left against medical advice” because the intended care was not completed
- Readmissions to critical access hospitals

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

Out of network Providers and services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care to Molina Members. Molina requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by federal or state Laws or regulations.

Avoiding conflict of interest

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

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

Coordination of care and services

Molina HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Molina's Integrated Care Management (ICM) program via assessment or referral such as, self-referral, Provider referral, etc. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end.

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

Continuity of care and transition of Members

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network Provider for a given period of time and 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 90 days, or longer if necessary, for a safe transfer to another Provider as determined by Molina or its delegated medical group
- 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 (800) 424-4518.

Continuity and coordination of Provider communication

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

Reporting of suspected abuse and/or neglect

A vulnerable adult is a person who is receiving or may need community care services by reason of mental or other disability, age or illness, and who is or may be unable to take care of themself or unable to protect themself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

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

- Physicians, dentists, interns, residents, or nurses.
- Public or private school employees or child care givers.
- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers. Suspected abuse and/or neglect should be reported as follows:

Child abuse

Virginia Department of Social Services Child Protective Services (CPS) CPS Hotline

- In Virginia: (800) 552-7096
- Out of state: (804) 786-8536
- Hearing-impaired: (800) 828-1120

Adult abuse

Virginia Department of Protective Services Adult

Adult Protective Services Hotline: (888) 832-3858

Molina's HCS teams will work with PCPs and medical groups 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, other delegated entities or other

clinical personnel. Under state and federal Law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self- neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Molina will follow up with Members that are reported to have been abused, exploited or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina will track, analyze, and report aggregate information regarding abuse reporting to the Health Care Services Committee and the proper state agency.

PCP responsibilities in care management referrals

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

Care manager responsibilities

The care manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions from Member's ICT as applicable. ICP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, Care Management to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the care manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the care manager:

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

Health Management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members.

Maternity screening and high-risk obstetrics

Molina offers to all pregnant Members prenatal health education with resource information as appropriate and screening services to identify high risk pregnancy conditions. Care managers with specialized OB training provide additional Care Management and health education for Members with identified high-risk pregnancies to assure best outcomes for Members and their newborns during pregnancy, delivery and through their sixth week post-delivery. Pregnant Member outreach, screening, education and care management are initiated by Provider notification to Molina, Member self-referral and internal Molina notification processes.

Providers can notify Molina of pregnant/ high risk pregnant Members via faxed pregnancy notification report forms.

Pregnancy notification process

The PCP shall submit to Molina the pregnancy notification report form (available at molinahealthcare.com) within one working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Molina at (800) 614-7934.

Member newsletters

Member Newsletters are posted on the molinahealthcare.com website at least once a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member health education materials

Members can access our easy-to-read evidenced-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression and other relevant health topics identified during our engagement with Members. Materials are available through the Member portal, direct mail as requested, email, and the My Molina mobile app.

Primary care Providers

Molina provides a panel of PCPs to care for its Members. Providers in the specialties of family medicine, internal medicine and obstetrics and gynecology are eligible to serve as PCPs.

Members may choose a PCP or have one selected for them by Molina. Molina's Members are required to see a PCP who is part of the Molina network. Molina's Members may select or change their PCP by contacting Molina Member Services.

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.

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

Care Management (CM)

Molina provides a comprehensive Intensive Case Management (ICM) program to all Members who meet the criteria for services. The ICM program focuses on coordinating the care, services and resources needed by Members throughout the continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina care managers may be licensed professionals and are educated, trained and experienced in Molina's ICM program. The ICM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency and to produce optimal outcomes. The ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina care manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina care manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of ICM

program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

Referral to care management: Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the CM program. The care manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP, and specialty Providers, such as discharge planners, ancillary Providers, the local Health Department or other community-based resources when identified. The referral source should be prepared to provide the care manager with demographic, health care and social data about the Member being referred.

Members with the following conditions may qualify for care management and should be referred to the Molina ICM program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic or end-stage medical conditions (e.g. neoplasm, organ/tissue

transplants, End- Stage Renal Disease)

- Comorbid chronic illnesses (e.g. asthma, diabetes, COPD, CHF, etc.)
- 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 by phone at (800) 424-4518 or by fax at (800) 614-7934.

8. BEHAVIORAL HEALTH

Overview

Molina provides a behavioral health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty Providers to ensure whole person care. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Behavioral health inpatient and residential services can be requested by submitting a prior authorization form or contacting Molina's prior authorization team at (800) 424-4518.

Providers requesting after-hours authorization for these services should utilize Provider portal or fax submission options. Emergency psychiatric services do not require prior authorization. All requests for behavioral health services should include the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted Medical Necessity criteria for prior authorization reviews. Please see the *Prior Authorization* subsection found in the *Health Care Services* section of this Provider Manual for additional information.

Access to Behavioral Health Providers and PCPs

Members may be referred to an in-network behavioral health Provider via referral from a PCP or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate behavioral health service within the scope of their practice. A formal referral form or prior authorization is not needed for a Member to self-refer or be referred to a PCP or behavioral health Provider.

Members may be referred to PCP and specialty care Providers to manage their health care needs. Behavioral health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Behavioral health Providers may identify other health concerns, including

physical health concerns, that should be addressed by referring the Member to a PCP.

Care Management and Continuity of Care

Discharge planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge.

Interdisciplinary Care Management

In order to provide care for the whole person, Molina emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral health, primary care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase

communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Molina's Care Management program may assist in coordinating care and communication amongst all Providers of a

Member's treatment team.

Care management

Molina's Care Management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and SUD needs. Members with high-risk psychiatric, medical or psychosocial needs may be referred by a behavioral health Provider to the ICM program.

Referrals to the ICM program may be made by contacting Molina at:

Phone: (800) 424-4518

Fax: (800) 614-7934

Additional information on the ICM program can be found in the *Care management* subsection found in the *Health Care Services* section of this Provider Manual.

Responsibilities of Behavioral Health Providers

Molina promotes collaboration with Providers and integration of both physical and behavioral health services in effort to provide quality Care Management to Members. Behavioral health Providers are expected to provide in-scope, evidence-based mental health and substance use

disorder services to Molina Members. Behavioral health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow Quality standards related to access. Molina provides oversight of Providers to ensure Members are able to obtain needed health services within the acceptable appointment timeframes. Please see the *Quality* chapter for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven days of the discharge date. If a Member misses a behavioral health appointment, the behavioral health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Line

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24/7 year-round. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling the Member Services telephone number listed on the back of their Molina Member ID card.

Behavioral Health Tool Kit for Providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to behavioral health HEDIS® tip sheets and other evidence-based guidance, and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both primary care and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the “Health Resources” tab on the molinahealthcare.com Provider website.

9. QUALITY

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement program. You can contact the Molina Quality department at (800) 424-4518.

The address for mail requests is:

Molina Healthcare

Attn: Quality Department 3829 Gaskins Road

Richmond, VA 23233

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

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

Molina does not delegate Quality Improvement activities to medical groups. However, Molina requires contracted medical groups to comply with the following core elements and standards of care. Molina medical groups/IPA's must:

- Have a Quality Improvement Program in place.
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential quality of care and/or critical incident investigations.
- Cooperate with Molina's quality improvement activities that are designed to improve
- quality of care and services and Member experience.
- Allow Molina to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, Care Management and management, service, and access and availability.
- Allow access to Molina Quality personnel for site and medical record review processes.

Patient Safety Program

Molina's Patient Safety program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe personal health practices for our Members through our safety program, pharmaceutical management and care management/disease management programs and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

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 a patient

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

Medical Records

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

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

Medical record keeping practices

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

- Each patient has a separate record
- Medical records are stored away from patient areas and preferably locked
- Medical records are available at each visit and archived records are available within 24 hours
- If hard copy, pages are securely attached in the medical record and records are organized
- by dividers or color-coded when thickness of the record dictates
- If electronic, all those with access have individual passwords
- Record keeping is monitored for Quality and HIPAA compliance
- Storage maintenance for the determined timeline and disposal per record management processes
- Process for archiving medical records and implementing improvement activities
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records

Content

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

- Each page in the record contains the patient's name or ID number
- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact
- Legible signatures and credentials of Provider and other staff members within a paper chart
- All Providers who participate in the Member's care
- Information about services delivered by these Providers
- A problem list that describes the Member's medical and behavioral health conditions
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed
- Allergies and adverse reactions (or notation that none are known)
- Documentation that Advanced Directives, power of attorney and living will have been discussed with Member, and a copy of Advance Directives when in place
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors
- Treatment plans that are consistent with diagnosis
- A working diagnosis that is recorded with the clinical findings
- Pertinent history for the presenting problem
- Pertinent physical exam for the presenting problem
- Lab and other diagnostic tests that are ordered as appropriate by the Provider
- Clear and thorough progress notes that state the intent for all ordered services and treatments
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate
- Notes from consultants if applicable
- Up-to-date immunization records and documentation of appropriate history
- All staff and Provider notes are signed physically or electronically with either name or initials
- All entries are dated
- All abnormal lab/imaging results show explicit follow up plan(s)
- All ancillary services reports

- Documentation of all emergency care provided in any setting
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report
- Labor and delivery record for any child seen since birth
- A signed document stating with whom protected health information may be shared

Organization

- The medical record is legible to someone other than the writer
- Each patient has an individual record
- Chart pages are bound, clipped, or attached to the file
- Chart sections are easily recognized for retrieval of information
- A release document for each Member authorizing Molina to release medical information for facilitation of medical care

Retrieval

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

Confidentiality

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

- Ensure that medical information is released only in accordance with applicable federal or state Law in pursuant to court orders or subpoenas
- Maintain records and information in an accurate and timely manner
- Ensure timely access by Members to the records and information that pertain to them
- Abide by all federal and state Laws regarding confidentiality and disclosure of medical records or other health and enrollment information

- Medical records are protected from unauthorized access
- Access to computerized confidential information is restricted
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information
- Education and training for all staff on handling and maintaining protected health care information

Additional information on medical records is available from your local Molina Quality department. For additional information regarding HIPAA please, refer to the *Compliance* section of this Provider manual.

Advance Directives (Patient Self-Determination Act)

Molina complies with the advance directive requirements of the States in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents**.**

Advance Directives are a written choice for health care. There are two types of Advance Directives:

- **Durable Power of Attorney for Health Care**: allows an agent to be appointed to carry out health care decisions.
- **Living Will**: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.

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, 18 years old and up, of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

Members who would like more information are instructed to contact Member Services or are directed to the CaringInfo website at caringinfo.org/planning/advance-directives/ for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

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

Molina network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. Molina will facilitate finding a new PCP or specialist as needed.

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

Molina will notify the Provider 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.

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs (adult and pediatric) and participating specialist (to include OB/GYN, behavioral health Providers, and high volume and high impact specialists). Providers are required to conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 90 percent availability for Emergency Services and 90 percent or greater for all other services. The PCP or their designee must be available 24 hours a day, seven days a week to Members.

Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted.

Medical appointment

Appointment types	Standard
Routine, primary care (Does not apply to appointments for routine physical exams, regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently, or routine specialty services like dermatology, allergy care, etc.)	Within 30 calendar days
Emergency care	Immediately
Urgent care	Within 24 hours

After hours care	24 hours/day; 7 day/week availability
LTSS	As expeditiously as Members condition requires, and no more than 5 business days from determination coverage is met
Maternity care 1st trimester	Within 7 days
Maternity care 2nd trimester	Within 7 days
Maternity care 3rd trimester	Within 3 days
High-risk pregnancy	Within 3 days of identifying the status of the Member's pregnancy

Behavioral health appointment

Appointment types	Standard
Life threatening emergency	Immediately
Non-life-threatening emergency	Within 6 hours
Urgent care	Within 48 hours
Initial routine care visit	Within 10 business days

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

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, seven days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an emergency to hang-up and call 911 or go immediately to the nearest emergency room. Voicemail alone after-hours is not acceptable.

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 (800) 424-4518 (TTY/TDD: 711).
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time.
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language interpretation.
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms.
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

   In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit their 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 their panel to new Members, Molina must receive 30 calendar day advance written notice from the Provider.

Women's Health Access

Molina allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a Participating PCP designated by Molina as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to Participating Providers for obstetrical and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

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

Monitoring Access for Compliance with Standards

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

Provider network adherence to access standards is monitored via one or more of the following mechanisms:

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

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

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors Member appeals and complaints/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical accessibility.
- Physical appearance.
- Adequacy of waiting and examining room space.

Physical accessibility

Molina evaluates office sites as applicable to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical appearance

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

Adequacy of waiting and examining room space

During the site visit as required, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation

includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration and Confidentiality of Facilities

Facilities contracted with Molina must demonstrate an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per Provider
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and epinephrine, plus any other medications appropriate to the practice
- At least one CPR certified employee is available
- Yearly OSHA training (fire, safety, blood-borne pathogens, etc.) is documented for offices with 10 or more employees
- A container for sharps is located in each room where injections are given
- Labeled containers, policies, and contracts, evidence of a hazardous waste management system in place
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked
- A CLIA waiver is displayed when the appropriate lab work is run in the office
- Prescription pads are not kept in exam rooms
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates
- Drug refrigerator temperatures are documented daily

EPSDT Services to Enrollees Under 21 Years of Age

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

Well Child/Adolescent Visits

Visits consist of age-appropriate components that include but are not limited to:

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

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.

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Performance below Molina's standards may result in a Corrective Action Plan

(CAP) with a request the Provider submit a written corrective action plan to Molina within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement program. The Quality Improvement program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services, regulatory, contractual and accreditation requirements, and strategic planning initiatives.

Health Management and Care Management

The Molina Health Management and Care Management programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases.

For additional information, please see the *Health Management* and *Care Management* headings in the *Health Care Services* section of this Provider Manual.

Clinical Practice Guidelines

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

Molina Clinical Practice Guidelines include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/panic disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar disorder
- Children with special health care needs
- Chronic kidney disease
- Chronic Obstructive Pulmonary Disease (COPD)

- Depression
- Diabetes
- Heart failure in adults
- Homelessness-special health care needs
- Hypertension
- Obesity
- Opioid management
- Perinatal care
- Pregnancy management
- Schizophrenia
- Sickle cell disease
- Substance abuse treatment
- Suicide risk
- Trauma-informed primary care

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

Individual Providers or Members may request copies from your local Molina Quality department.

Preventive Health Guidelines

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

- Adult preventive services recommendations
- Recommendations for preventive pediatric health care
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States, 2021
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

All guidelines are updated at least annually and more frequently as needed when clinical evidence changes and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to Providers at molinahealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is

published in the Molina Provider newsletter.

Cultural and Linguistic Services

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina's program and services, please see the *Cultural Competency and Linguistic Services* section of this Provider Manual.

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS ®)
- Behavioral health satisfaction assessment
- Provider satisfaction survey
- Effectiveness of quality improvement initiatives

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

Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or Facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of quality improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

Molina's most recent results can be obtained from your local Molina Quality department or by visiting our website at molinahealthcare.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are the measurement standard for

many of Molina's clinical quality activities and health improvement programs. The standards

are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is the tool used by Molina to summarize Member satisfaction with the Providers, 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 satisfaction assessment

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

Provider satisfaction survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey both focus on Member experience with health care Providers and health plans, Molina conducts a Provider satisfaction survey annually. The results from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider network. The survey results have helped establish improvement activities

relating to Molina's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of quality improvement initiatives

Molina monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices". The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, Molina also compiles complaint and appeals data as well as 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.
- Be sure patients understand what *they* need to do.

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Provider portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Molina Quality department.

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

10. RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

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

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

Why is Risk Adjustment Important?

Molina relies on our Provider network to take care of our Members based on their health care needs. Risk adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies

opportunities for gap closure for future visits. In addition, risk adjustment allows us to:

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

Your Role as a Provider

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

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

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

Interoperability

Provider agrees to deliver relevant clinical documents (CDA or CCD format) at encounter close for Molina Members by using one of the automated methods available and supported by their EMR, including, but not limited to, Direct protocol, sFTP, query or web service interfaces such as SOAP (XDR) or REST (FHIR). CCDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and HL7 Consolidated Clinical Data Architecture (CCDA) standard.

Providers will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

Provider will participate in Molina's program to communicate clinical information using the Direct protocol. Direct protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging healthcare information that is approved by the Office of the National Coordinator for Health Information Technology (ONC) and is used by all 2015 Certified Electronic Health Record Technology (EHR) platforms.

- If Provider does not have Direct address, Provider will work with its EHR vendor to set up a Direct account, which also supports the Centers for Medicare & Medicare Services (CMS) requirement of having Provider's digital contact information added in the National Plan and Provider Enumeration System (NPPES).
- If Provider's EHR does not support the Direct protocol, Provider will work with Molina's established interoperability partner to get an account established.

RADV Audits

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

Contact Information

For questions about Molina's Risk Adjustment programs, please contact your Molina Provider Services representative.

11. COMPLIANCE

Fraud, Waste and Abuse

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal

statutes and regulations pertaining to fraud, waste and abuse. The plan also addresses fraud, waste and abuse prevention and detection along with and the education of appropriate employees, vendors, Providers and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to detect, 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 detect, prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Regulatory requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent Claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the Claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a Claim; or,
- Acts in reckless disregard of the truth or falsity of the information in a Claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent Claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false Claim to be submitted.

Deficit Reduction Act

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

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

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

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

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in

disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole including:

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

Affected entities who fail to comply with the Law will be at risk of forfeiting all payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the Law.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute ("AKS") is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

Molina conducts all business in compliance with Federal and State Anti-Kickback Statutes (AKS) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKS?

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. **Examples** of prohibited AKS actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under **Molina's policies**, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of Federal health care program business. Providers must not, directly, or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing Guidelines and Requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both State and Federal.

Under **Molina's policies**, Marketing means any communication, to a beneficiary who is not enrolled with Molina, that can reasonably be interpreted as intended to influence the beneficiary to enroll with Molina's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another Health Plan's products.

Restricted marketing activities vary from state-to-state but generally relate to the types and form of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark Statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare of Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law [42 U.S.C. § 1395nn].

Sarbanes-Oxley Act of 2002

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

Anti-Kickback Statute—Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other Federal health care programs

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

Sarbanes-Oxley Act of 2002—Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess

the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other

person. It includes any act that constitutes fraud under applicable federal or state Law. (42 CFR § 455.2)

Waste: Health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g., coding) causing unnecessary costs to state and federal health care programs.

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

Examples of fraud, waste and abuse by a Provider

The types of questionable Provider schemes investigated by Molina include, but are not limited to the following:

- A 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 higher level of reimbursement
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees
- Billing and providing for services to Members that are not Medically Necessary
- Billing for services, procedures and/or supplies that have not been rendered
- Billing under an invalid place of service in order to receive or maximize reimbursement
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider
- Concealing a Member's misuse of a Molina identification card
- Failing to report a Member's forgery or alteration of a prescription or other medical document
- False coding in order to receive or maximize reimbursement
- Inappropriate billing of modifiers in order to receive or maximize reimbursement
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients

- Not following incident to billing guidelines in order to receive or maximize reimbursement
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges
- Questionable prescribing practices
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code
- Underutilization, which means failing to provide services that are Medically Necessary
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more
- Using the adjustment payment process to generate fraudulent payments

Examples of fraud, waste and abuse by a Member

The types of questionable Member schemes investigated by Molina include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits
- Conspiracy to defraud state and federal health care programs
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services
- Falsifying documentation 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 system

Molina Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance department.

The Claims payment system utilizes system edits and flags to validate those elements of Claims are billed in accordance with standardized billing practices; ensure that Claims are processed accurately and ensure that payments reflect the service performed as authorized.

Molina performs auditing to ensure the accuracy of data input into the Claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment fraud, waste and abuse detection activities

Through implementation of Claims edits, Molina's Claims payment system is designed to audit Claims concurrently, in order to detect and prevent paying Claims that are inappropriate.

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

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

Post-payment recovery activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at Law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Members.

Auditable documents and records include, but are not limited to medical charts, patient charts, billing records and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to Provider's records, all of the Claims for which Provider received payment from Molina is immediately due and owing. If Provider fails to provide all requested documentation for any Claim, the entire amount of the paid Claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Claim auditing

Molina shall use established industry Claims adjudication and/or clinical practices, state, and federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding and payment.

Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical

records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an Overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims 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.

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.

Reporting fraud, waste and abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available 24 hours a day, seven days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached toll free at (866) 606-3889 or you may use the service's website to make a report at any time at MolinaHealthcare.alertline.com.

You may also report cases of fraud, waste or abuse to Molina's Compliance department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare, Inc. Attn: Compliance

200 Oceangate Blvd.
Suite 100
Long Beach, CA 90802

Remember to include the following information when reporting:

- Nature of complaint
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Molina Member ID number and any other identifying information

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

Department of Medical Assistance Services Recipient Audit Unit
600 East Broad Street, Suite 1300
Richmond, VA 23219

Toll Free Phone: (800) 371-0824

Email: Recipientfraud@DMAS.virginia.gov
Website: https://www.dmas.virginia.gov/

HIPAA (Health Insurance Portability and Accountability Act) Requirements and Information

Molina's commitment to patient privacy

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

Provider responsibilities

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

Telehealth/telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal Law, including:

- 42 C.F.R. Part 2 Regulations
- Health Information Technology for Economic and Clinical Health Act, (HITECH Act)

Applicable Laws

Providers must understand all state and federal health care privacy Laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of Laws that Providers must comply with. In general, most health care Providers are subject to various Laws and regulations pertaining to privacy of health information, including, without limitation, the following:

1. Federal Laws and regulations

- HIPAA
- The Health Information Technology for Economic and Clinical Health Act (HITECH)
- 42 C.F.R. Part 2
- Medicare and Medicaid Laws
- The Affordable Care Act

2. State medical privacy Laws and regulations

Providers should be aware that HIPAA provides a floor for patient privacy, but that state Laws should be followed in certain situations, especially if the state Law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the

Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of services[2].
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being

See, Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.

[2]See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

- Quality improvement
- Disease management
- Care Management and Care Coordination
- Training programs
- Accreditation, licensing and credentialing

Importantly, this allows Providers to share PHI with Molina for our health care operations activities, such as HEDIS® and Quality Improvement.

Confidentiality of substance use disorder patient records

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

Inadvertent disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written authorizations

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state Law.

Patient rights

Patients are afforded various rights under HIPAA. Molina Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. Notice of privacy practices

Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for restrictions on uses and disclosures of PHI**

   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for confidential communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for patient access to PHI**

   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to amend PHI**

   Patients have a right to request that the Provider amend information in their designated record set.

6. **Request accounting of PHI disclosures**

   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cybersecurity measures. Providers should recognize that identity

theft—both financial and medical—is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity—such as health insurance information—without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA transactions and code sets

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

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

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at molinahealthcare.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to

Molina within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina.

Additional requirements for delegated Providers

Providers that are delegated for Claims and utilization management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for copies of PHI

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

- Utilization management
- Care Management and/or complex medical care management services
- Claims review
- Resolution of an appeal and/or grievance
- Anti-fraud program review
- Quality of care issues
- Regulatory audits
- Risk adjustment
- Treatment, payment and/or operation purposes
- Collection of HEDIS® medical records

Business Continuity Plan (BCP)

The Provider will have a documented Business Continuity Plan (BCP) to ensure continuation and recovery of services after a disruption occurs. The BCP will be updated at least annually and approved by the applicable designated representative.

The Provider Business Continuity Plan will include:

- Names and contact information for staff responsible for invoking and managing response and recovery.
- Molina notification names and contact information.
- Disaster declaration process.
- Details of how the services will be recovered and restored.
- Details of how the systems and applications supporting the services will be recovered and restored, including recovery of data.

The Provider will notify Molina of a disruption to the services or activation of business continuity plans within two hours and will provide Molina with regular updates on the situation and actions taken to resolve the issue, until normal services have been resumed.

The Provider will ensure that its third parties needed to deliver the services have appropriate Business Continuity Plans in place to prevent significant disruption to the services.

The Provider will test the BCP at least annually and document the test results. Provider will make available to Molina, upon request, the results of the most recent test including lessons learned and remediation plans.

The Provider will participate in Molina annual tests upon notification and mutual agreement.

After disruption to services, once normal service has been resumed, the Provider will promptly complete a root cause analysis report and provide it to Molina.

Definitions

Business Continuity Plan: Documented procedures that guide organizations to respond, recover, resume and restore to a pre-defined level of operations following a disruption

Disaster Recovery Plan: A document that defines the resources, actions, tasks and data required to manage the technology recovery effort

Disaster Declaration: Criteria to declare a disaster and the staff authorized to invoke recovery plans to recover and restore services

Information Security and Cybersecurity

Note: This section (Cybersecurity Requirements) is only applicable to Providers who are delegated Providers and have been delegated by Molina to perform a health plan function.

1. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by Law or any enforcement agency.
2. The following terms are defined as follows:
    I. "Consumer" means an individual who is a state resident, whose nonpublic information is in Molina's possession, custody or control and which Provider maintains, processes, stores or otherwise has access to such nonpublic information.
    II. "Cybersecurity Event" means any act or attempt, successful or, to the extent known by Provider, unsuccessful, to gain unauthorized access to, disrupt or misuse an information system or nonpublic information stored on such information system. The ongoing existence and occurrence of attempted but unsuccessful security incidents shall not constitute a cybersecurity event under

this definition. "Unsuccessful security incidents" are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Molina nonpublic information or sustained interruption of service obligations to Molina.

III. "Information system" or "Information systems" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic nonpublic information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems and environmental control systems.

IV. "Nonpublic information" means information that is not publicly available information and is one of the following:

(a) Business related information of Molina the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Molina;

(b) Any information concerning a consumer that because of the name, number, personal mark, or other identifier contained in the information can be used to identify such consumer, in combination with any one or more of the following data elements:

(i) Social security number;

(ii) Driver's license number, commercial driver's license or state identification card number;

(iii) Account number, credit or debit card number;

(iv) Security code, access code, or password that would permit access to a consumer's financial account; or

(v) Biometric records;

(c) Any information or data, except age or gender, in any form or medium created by or derived from a health care Provider or a consumer, that can be used to identify a particular consumer, and that relates to any of the following:

(i) The past, present, or future physical, mental or behavioral health or condition of a consumer or a member of the consumer's family;

(ii) The provision of health care to a consumer; or

(iii) Payment for the provision of health care to a consumer.

V. "State" means the state of Virginia.

3. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the information systems and nonpublic information, as defined herein, that are accessible to, or held by, the Provider. Implementation of the foregoing measures shall incorporate guidance issued by the State Department of Insurance, as appropriate.

4. Provider agrees to comply with all applicable Laws governing cybersecurity events. Molina will decide on notification to affected consumers or government entities. Upon Molina's prior written request, Provider agrees to assume responsibility for informing all such consumers in accordance with applicable Law.
5. In the event of a cybersecurity event, Provider shall notify Molina's Chief Information Security Officer of such cybersecurity event by telephone and email (as provided below) as promptly as possible, but in no event later than 72 hours from a determination that a cybersecurity event has occurred. A follow-up notification shall be provided by mail, at the address indicated below.

   Notification to Molina's Chief Information Security Officer shall be provided to:

   Molina Chief Information Security Officer
   Telephone: (844) 821-1942
   Email: CyberIncidentReporting@MolinaHealthcare.com

   Molina Chief Information Security Officer
   Molina Healthcare, Inc.
   200 Oceangate Blvd., Suite 100
   Long Beach, CA 90802

6. Upon Provider's notification to Molina of a determination of a cybersecurity event, Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation, or, upon written request by Molina, Provider shall complete an investigation pursuant to the following requirements:
   (a) Determine whether a cybersecurity event occurred;
   (b) Assess the nature and scope of the cybersecurity event;
   (c) Identify nonpublic information that may have been involved in the cybersecurity event; and
   (d) Perform or oversee reasonable measures to restore the security of the information systems compromised in the cybersecurity event to prevent further unauthorized acquisition, release, or use of the nonpublic information.
7. Provider shall maintain records concerning all cybersecurity events for a period of at least five years from the date of the cybersecurity event or such longer period as required by applicable Laws and produce those records upon request of Molina.
8. Provider must provide to Molina the documentation required and requested by Molina in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the cybersecurity event. The information provided to Molina in the initial and subsequent notices must include as much of following information known to Provider at the time of the notification:

   (a) The date of the cybersecurity event;
   (b) A description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Provider, if any;

(c) How the cybersecurity event was discovered;
(d) Whether any lost, stolen, or breached information has been recovered and if so, how this was done;
(e) The identity of the source of the cybersecurity event;
(f) Whether Provider has filed a police report or has notified any regulatory, governmental or Law enforcement agencies and, if so, when such notification was provided;
(g) A description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer;
(h) The period during which the information system was compromised by the cybersecurity event;
(i) The number of total consumers in the state affected by the cybersecurity event;
(j) The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
(k) A description of efforts being undertaken to remediate the situation which permitted the cybersecurity event to occur;
(l) A copy of Provider's privacy and security policies and if requested by Molina, the steps that Provider will take to notify consumers affected by the cybersecurity event;
(m) The name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider; and
(n) Provide updates every 15 calendar days the status of the incident until fully resolved.

9. Provider agrees to fully cooperate with any security risk assessments or audits performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments.

In the event provisions of this section conflict with provisions of any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

12. CLAIMS AND COMPENSATION

Payor ID	MCC02
Provider portal	provider.MolinaHealthcare.com
Clean Claim timely filling	180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services for in network Providers. 360 calendar days after the discharge for inpatient services or the Date of Service for outpatient services for out of network Providers.

Electronic Claims Submission

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

- Helps to reduce operation costs associated with paper Claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Provider portal
- Submit Claims to Molina via your regular EDI clearinghouse

Provider Portal

The Provider portal is a no cost online platform that offers a number of Claims processing features:

- Submit professional (CMS1500) and institutional (UB04) Claims with attached files
- Correct/void Claims
- Add attachments to previously submitted Claims
- Check Claims status
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
- Create and manage Claim templates
- Create and submit a Claim appeal with attached files

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 email us at EDI.Claims@MolinaHealthcare.com for additional support.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within 180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services for in network Providers. Out of network Providers must submit Claims within 365 calendar days from Date of Service for outpatient Claims or date of discharge for inpatient services. If Molina is not the primary payer under coordination of benefits or third-party liability, the primary insurance Explanation of Payment (EOP) or Medicare Summary Notice (MSN) is used to determine the timely filing deadline. For these Claims, the time frame begins with the print date on the primary insurance EOP or MSN. Except as otherwise provided by Law or provided by government program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must adhere to Provider and service-specific instructions as defined, which ensures that the required Molina Encounter Data will be accepted by DMAS and/or the state's Encounter Data warehouse. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or the Provider portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims).

Providers must bill Molina for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

National Provider Identifier (NPI)

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

Required Elements

The following information must be included on every Claim:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid diagnosis pointers
- Total billed charges
- Place and type of service code
- Days or units as applicable
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI)
- Rendering Provider name as applicable
- Billing/pay-to Provider name and billing address
- Place of service and type (for facilities
- Disclosure of any other health benefit plans

- E-signature
- Service facility location information

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

Paper Claim Submissions

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

Molina Healthcare of Virginia, LLC
PO Box 22656
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.

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and UB-04 forms.

Corrected Claims may be submitted electronically via EDI, the Provider portal.

All corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white UB-04 or CMS-1500 Claim form (paper Claims).
- Must have original Claim number inserted in field 64 of the UB-04 or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected Claims electronically.
- Must have the appropriate frequency code/resubmission code must billed in field 4 of the UB-04 and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms or the UB Editor (Uniform Billing Editor) for UB- 04 Claim forms.

Corrected Claims must be sent within 180 calendar days of the original Claim paid date.

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).

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

COB

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina or medical groups. 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 (EOB) and other required documents, by utilizing the Provider portal. Providers can also submit this information through EDI and paper submissions.

TPL

Molina is the payer of last resort and will make every effort to determine the appropriate third- party payer for services rendered. Molina may deny Claims when Third Party has been established and will process Claims for Covered Services when probable TPL has not been established or third-party benefits are not available to pay a Claim. Molina 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.

Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

The following is a list of CMS Hospital Acquired Conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1) Foreign object retained after surgery
2) Air embolism
3) Blood incompatibility
4) Stage III and IV pressure ulcers
5) Falls and trauma
    a) Fractures
    b) Dislocations
    c) Intracranial injuries
    d) Crushing injuries
    e) Burn
    f) Other injuries
6) Manifestations of poor glycemic control
    a) Hypoglycemic coma
    b) Diabetic ketoacidosis
    c) Non-ketotic hyperosmolar coma
    d) Secondary diabetes with ketoacidosis
    e) Secondary diabetes with hyperosmolarity
7) Catheter-associated Urinary Tract Infection (UTI)
8) Vascular catheter-associated infection
9) Surgical site infection following coronary artery bypass graft—Mediastinitis
10) Surgical site infection following certain orthopedic procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
11) Surgical site infection following bariatric surgery procedures for obesity
    a) Laparoscopic gastric restrictive surgery
    b) Laparoscopic gastric bypass
    c) Gastroenterostomy
12) Surgical site infection following placement of cardiac implantable electronic device (CIED)
13) Iatrogenic pneumothorax with venous catheterization

14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following certain orthopedic procedures
    a) Total knee replacement
    b) Hip replacement

What this means to Providers

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

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: cms.hhs.gov/HospitalAcqCond/

Molina Coding Policies and Payment Policies

Frequently requested information on Molina's coding policies and payment policies is available on the molinahealthcare.com website under "Other Resources and Policies" heading in the "Provider
Resources" tab. Questions can be directed to your Provider Services representative.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. Molina requires coding of both diagnoses and procedures for all Claims. 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, Current Procedural Terminology 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 & Medicaid Services (CMS), including:
    - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a state benefit limit is more stringent/restrictive than a federal MUE,

Molina will apply the state benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or state benefit limit the professional organization standard may be used

    - In the absence of state guidance, Medicare National Coverage Determinations (NCD)
    - In the absence of state guidance, Medicare Local Coverage Determinations (LCD).
    - CMS Physician Fee Schedule RVU indicators
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA)
- ICD-10 guidance published by the National Center for Health Statistics
- State-specific Claims reimbursement guidance
- Other coding guidelines published by industry-recognized resources
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than state and federal guidelines
- Molina policies based on the appropriateness of health care and Medical Necessity
- Payment policies published by Molina

Telehealth Claims and Billing

Providers must follow CMS guidelines as well as state-level requirements.

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type. Modifier GQ/GT is required when applicable. Distant site Providers must include the modifier GT on Claims for services delivered via telemedicine. GT represents services provided in real-time (such as through video consultations). GQ represents services provided not in real time such as remote patient monitoring or “store-and-forward” of information like photographs. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. Molina uses NCCI standard payment methodologies.

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

comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

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

CPT and HCPCS Codes

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

Modifiers

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

- Service or procedure has a professional component.
- Service or procedure has a technical component.
- Service or procedure was performed by more than one physician.
- Unilateral procedure was performed.
- Bilateral procedure was performed.
- Service or procedure was provided more than once.
- Only part of a service was performed.

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

ICD-10-CM/PCS Codes

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

Place Of Service (POS) Codes

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

Type of Bill

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

Revenue Codes

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

Diagnosis Related Group (DRG)

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

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

National Drug Code (NDC)

The 11-digit National Drug Code 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.

Claim Auditing

Molina shall use established industry claims adjudication and/or clinical practices, state and federal guidelines and/or Molina's policies and data to determine the appropriateness of the billing, coding and payment.

Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an Overpayment.

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

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

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, 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.

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group have agreed in writing to an alternate schedule, Molina will generally process the claim for service within 30 days after receipt of Clean Claims.

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

Electronic Claim Payment

Participating Providers are strongly encouraged to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at molinahealthcare.com or by contacting our Provider Services department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an Overpayment notification letter if the Overpayment is identified in accordance with state and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy Overpayment,

2. Submit request to offset from future Claim payments, or
3. Dispute Overpayment findings.

Instructions will be provided on the Overpayment notice and Overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the other carrier name, policy number, effective date, term date and subscriber information. For Members with Commercial COB, Molina will provide notice within 270 days from the Claim's paid date if the primary insurer is a Commercial plan. A Provider may resubmit the Claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the Claim and pay or deny the Claim in accordance with Claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the Overpayment amount(s) against future payments made to the Provider.

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

Claim Disputes/Reconsiderations

Providers disputing a Claim previously adjudicated must request a Claim reconsideration within 60 days of Molina's original remittance advice date. Regardless of type of denial/reconsideration (service denied, incorrect payment, administrative, etc.); all Claim reconsiderations must be submitted on the proper form, locate on the molinahealthcare.com website.

For additional Claim reconsideration details and instructions, please see the "Provider Reconsiderations and Appeals" sub-section of the *Grievance and Appeals Process* chapter of this manual.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment,

coinsurance and deductible amounts.

Fraud and Abuse

Failure to report instances of suspected fraud and abuse is a violation of the Law and subject to the penalties provided by Law. Please refer to the *Compliance* section of this Provider manual for more information.

13. GRIEVANCE AND APPEALS PROCESS

Member Grievance and Appeals System

Molina is required to have a system in place to respond to grievances, appeals and complaints received from Members, and we are required to provide to all network Providers and subcontractors information about the grievance and appeals processes. Molina ensures that individuals making decisions regarding grievances or appeals:

- Are not involved in any previous level of review or decision making or a subordinate of the decision maker.
- Have the appropriate clinical expertise to make the decision.

Molina is not responsible for handling appeals related to carved-out or excluded services.

Member Grievance Process

In accordance with 42 CFR § 438.400, a grievance is an expression of dissatisfaction about any matter other than an "adverse benefit determination." A grievance is any complaint or dispute expressing dissatisfaction with any aspect of Molina or a Provider's operations, activities, or behavior. A grievance may be filed at any time. With the Member's written consent, a Provider or authorized representative may file a grievance on behalf of a Member. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a PCP or employee of Molina, or failure to respect the Member's rights, as provided for in 42 CFR § 438.400 et seq. Molina will maintain a system that meets, at a minimum, the following standards:

- Timely acknowledgement of receipt of each Member grievance
- Timely review of each Member grievance
- Standard response, electronically, or in writing, to each Member grievance within a reasonable time, but no later than 90 days after Molina receives the grievance.

Whenever Molina extends the appeal timeframe or refuses to grant a request for an expedited appeal, the Member needs to be notified orally or in writing with 24 hours

In some cases, Molina will submit a request to DMAS to extend the time frames for

resolution of grievances by up to 14 calendar days. The request for extension can be requested by a Member, if Molina provides evidence of the need for additional information and proof that the delay would be in the Member's best interest. The Member will receive a written response from Molina.

Grievance forms are available online at molinahealthcare.com. If the Member or their authorized designee (Provider, family member, etc.) needs help with filing a grievance, please call the Member Services department toll-free at (800) 424-4518.

Interpreter services are available. Our Member Services department is available from 8 a.m. to 8 ET, Monday through Friday.

To file a grievance, Members can call us toll free at (800) 424-4518.

Or mail the grievance to:

Molina Healthcare
Attn: Complaint Coordinator
PO Box 36030
Louisville, KY 40233-6030

Member Appeals Process

Molina supports the right of our Members to request a review of adverse actions or benefit determinations ("adverse determination"). We accept appeal requests from our Members, their authorized representatives, and their Providers for any Covered Service that has been denied, reduced, suspended or terminated. A Member's authorized representative may be anyone who is authorized to file the appeal request on behalf of the Member, so long as the Member has provided written permission. Examples of designees include a family member, legal guardian or attorney.

Standard appeals process and timeline

Members may file an appeal with Molina within 60 calendar days from the date on the adverse benefit determination notice. Appeals may be filed verbally, in writing, via fax.

To file an appeal, Members can call us toll free at (800) 424-4518.

Interpreter services are available. Our Member Services department is available from 8 a.m. to 8 p.m., ET, Monday through Friday.

If needed, our agents will help complete the appeal request. Members can send their written appeal to Molina by:

Mail:

Molina Healthcare

Attn: Complaint Coordinator PO Box 36030

Louisville, KY 40233-6030

Fax: 1-866-325-9157

Molina will make a decision on an appeal within 30 calendar days from the initial date of receipt of the appeal. The written notification will include the decision, and in the case of a denial or partial denial, the reason for denial, including information on their second level appeal rights through the State Fair Hearing process with DMAS.

Expedited appeal

Molina has an expedited review process for appeals if we or the Member's Provider determines that the time expended in a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. If you are filing an expedited appeal on behalf of a Molina Member, we will make a decision within 72 hours from the initial receipt of the expedited appeal.

Continuation of benefits

While the appeal decision is being made, the Member can continue to receive care for previously authorized services if the Member requests continuation of benefits either within 10 days of the date on the notice of adverse benefit determination, or by the date the change in services is scheduled to occur. If the final decision is not in the Member's favor, the Member

may be charged. If the final decision is in the Member's favor, services will be reinstated within 72 hours for expedited and standard appeals.

State Fair Hearing

Members, their authorized representatives, or their Provider have a right to appeal Molina's adverse determination on their appeal request through the State Fair Hearing process. Completion of Molina's appeal process is a prerequisite to filing for a State Fair Hearing. A Member is also able to file for a State Fair Hearing if Molina fails to adhere to the required timeframes for processing the Member's appeal. DMAS conducts evidentiary hearings in accordance with regulations at 42 CFR § 431(E) and 12 VAC 30-110-10 through 12 VAC 30-110-370.

The appeal for a State Fair Hearing must be filed within 120 days after receipt of Molina's appeal decision. Standard appeals must be requested in writing to DMAS by the Member or their authorized representative. DMAS will resolve these within 90 days of the date of filing the appeal. Expedited appeals may be filed by telephone or in writing. DMAS will resolve these within 72 hours. Members needing assistance filing a State Fair Hearing appeal can call Molina at (800) 424-4518.

Interpreter services are available. Our Member Services department is available from 8 a.m. to 8 p.m. EST, Monday through Friday.

Molina will attend and defend our appeals decisions at all hearings or conferences in person or on the phone, as deemed necessary by DMAS.

If DMAS reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, Molina must authorize the disputed services no later than 72 hours from the date Molina receives the notice reversing the decision. Molina does not have the right to appeal DMAS's appeal decisions.

FAMIS Members do not receive State Fair Hearings. After exhausting Molina appeal rights, FAMIS Members must submit any further appeal to KEPRO, DMAS's external review organization, at:

KEPRO External Review
2810 N. Parham Road Suite #305
Henrico, Virginia 23294

A FAMIS Member may also submit a written request via secure link on the KEPRO website at dmas.kepro.com by clicking on the external appeal link. The Member must submit a request for external review within 30 days of the MCO's appeal decision.

Continuation of benefits

While the State Fair Hearing decision is being made, the Member can continue to receive care for previously authorized services if the Member requests continuation of benefits either within 10 days of the date on the notice of adverse benefit determination, or by the date the change in services is scheduled to occur. If the final decision is not in the Member's favor, the Member may be charged. If the final decision is in the Member's favor, services will be reinstated within 72 hours.

Provider Reconsiderations and Appeals

Provider reconsiderations

Provider appeals are requests made by Molina Providers (in-network and out-of-network) to review Molina's adverse benefit determination in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a Provider exhausts Molina's internal appeal process, Virginia Medicaid affords the Provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act (Code of Virginia Section 2.2-4000 et seq.) and Virginia Medicaid's Provider appeal regulations (12 VAC 30-20-500 et seq.).

Providers may submit reconsiderations to Molina if a Provider has rendered services to a Member and has been denied authorization/reimbursement for services or has received reduced authorization/reimbursement.

A Provider may file an appeal with Molina within 60 calendar days from the date of the adverse benefit determination notice/remittance advice. Failure to file an appeal with Molina within this timeliness standard shall result in an administrative dismissal.

We will not conduct Medical Necessity retro authorization review through the Provider Claims appeal/reconsideration process, except in the following circumstances:

- Emergency Medical Treatment and Labor Act (EMTALA)—Provider must indicate this on appeal
- Claim was legitimately submitted to the incorrect Managed Care Organization (MCO)—Provider must include a copy of the admit form documenting the name of the MCO the Member was enrolled in, and a copy of the remittance advice documenting the denial of the Claim as not being enrolled in the MCO within 30 calendar days of the date of the Explanation of Payment
- "John" or "Jane" Doe admission—Provider must submit a copy of the admission sheet or other supporting records documenting that the coverage was not known
- The service is directly related to another service for which prior approval has already been obtained and that has already been performed
- The new service was not a known need at the time the original authorization was obtained
- MCO denied the service due to the Member having primary insurance at the time authorization was submitted

A Provider must file the appeal with Molina in writing, although the appeal may be started verbally. The appeal must identify the issues, adjustments or items the Provider is appealing and include any supporting documentation, which explains or satisfies the reason for the original denial and why it should be paid accordingly.

To file an appeal:

- Call:

  Cardinal Care Managed Care (800) 424-4518

We're available from 8:00 a.m. to 6:00 p.m. ET, Monday through Friday. Providers can leave a message after hours that will be returned on the next business day.

Mail:

Molina Healthcare Attn: Appeals Specialist PO Box 36030

Louisville, KY 40233-6030

Fax: 1-866-325-9157

Appeal resolution

All Provider appeals will be thoroughly investigated using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying Molina written policies and procedures. At the conclusion of the review, which shall not exceed 30 days, the Provider will receive a written decision with an explanation of the decision.

For appeals not resolved wholly in favor of the Provider, Molina's written Notice of Internal Appeal Decision will include the description of appeal rights for a DMAS informal and formal appeal, including the address for filing the appeal, the timeframe, and the list of pertinent statutes/regulations governing the appeal process.

Informal and formal appeals rights

Medicaid Providers have the right to appeal adverse decisions to DMAS. However, Molina's internal appeal process must be exhausted prior to a DMAS Provider filing an appeal with the DMAS Appeals division. All Provider appeals to DMAS must be submitted in writing and within 30 calendar days of Molina's last date of denial to:

DMAS Appeals Division 600 East Broad Street Richmond, VA 23219

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in Virginia Code 2.2-4000 et seq. and 12 VAC 30-20-500 et seq. There are two levels of sequential administrative appeal: (i) the informal appeal and (ii) the formal appeal.

The informal appeals decision shall be issued within 180 calendar days of receipt of the notice of informal appeal. If the informal appeal decision is adverse to the Provider, the Provider has the right to file a formal appeal with DMAS within 30 calendar days of the Provider's receipt of the DMAS informal appeal decision.

The formal appeal shall identify each adjustment, patient, service date or other disputed matter that the Provider is appealing. Failure to file the formal appeal within the timeliness standard will result in an administrative dismissal. The hearing officer for the formal appeal will submit a recommended decision to the DMAS director with a copy to the Provider

within 120 calendar days of the filing of the formal appeal notice. Further information on either the informal or formal appeals process can be obtained from DMAS.

Reporting

Grievance and appeal trends are reported to the Quality Improvement Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement Committee for evaluation. If required by the state or CMS, reporting is submitted to the appropriate agency as needed.

Record Retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of 10 years. In addition to the information documented electronically via call tracking in QNXT or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than 10 years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain health plan's prior approval for the disposition of records if agreement is continuous.)

14. CREDENTIALING AND RECREDENTIALING

The purpose of the Credentialing program is to assure that 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, gender identity, age, sexual orientation, ancestry, religion, marital status, health status or patient types (e.g. Medicaid) in which the Practitioner

specializes. This does not preclude Molina from including in its network Practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Types Of Practitioners Credentialed & Recredentialed

Practitioners and groups of Practitioners with whom Molina contracts must be credentialed prior to the contract being implemented.

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care practitioners who are licensed, certified or registered by the state to practice independently
- Chiropractors
- Clinical social workers
- Dentists
- Doctoral or master's-level psychologists
- Licensed/certified midwives (non-nurse)
- Massage therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse midwives
- Nurse Practitioners
- Occupational therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and language pathologists

- Telemedicine Practitioners

Criteria for Participation in The Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of 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 Practitioner to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete, and it will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application**—Practitioners must submit to Molina a complete credentialing application either from CAQH ProView or other state mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, certification or registration**—Practitioners must hold 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**—Practitioners must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Practitioner must have a DEA or CDS in every state where the Practitioner provides care to
- Molina Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions

requiring a DEA number.

- **Specialty**—Practitioner must only be credentialed in the specialty in which they have adequate education and training. Practitioner must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education**—Practitioner must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency training**—Practitioner must have satisfactorily completed residency programs
- from accredited training programs in the specialties in which they are practicing. Molina only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three-year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.
- **Fellowship training**—If the Practitioner is not board certified in the specialty in which they
- practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board certification**—Board certification in the specialty in which the Practitioner is
- practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following boards:
    - American Board of Medical Specialties (ABMS)
    - American Osteopathic Association (AOA)
    - American Board of Foot and Ankle Surgery (ABFAS)
    - American Board of Podiatric Medicine (ABPM)
    - American Board of Oral and Maxillofacial Surgery
    - American Board of Addiction Medicine (ABAM)
    - College of Family Physicians of Canada (CFPC)
    - Royal College of Physicians and Surgeons of Canada (RCPSC)
    - Behavioral Analyst Certification Board (BACB)
    - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners**—Practitioners who are not board certified and have not completed a training 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 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 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**—Practitioners must supply most recent five-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the Practitioner must clarify the
- **Gap verbally or in writing**. The organization will document a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one year, the Practitioner must clarify the gap in writing.
- **Malpractice history**—Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State sanctions, restrictions on licensure or limitations on scope of practice**—Practitioners must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioners 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 body3. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
- **Medicare, Medicaid and other sanctions and exclusions**—Practitioners must not be currently sanctioned, excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for

debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.

- **Medicare opt out**—Practitioners currently listed on the Medicare Opt-Out Report may not
- participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File**—Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List**—Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional liability insurance**—Practitioners must have and maintain professional
- malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioners activities on Molina's behalf. Practitioners maintaining coverage under a federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to perform**—Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable

[3]If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

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 of the following:
    - Criminal convictions including convicts, guilty pleas or adjudicated pretrial diversions for crimes against person such as murder, rape, assault and other similar crimes
    - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes
    - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct
    - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act
    - Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances or similar crimes

At the time of initial credentialing, Practitioners must not have any pending criminal charges in the categories listed above.

- **Loss or limitations of clinical privileges**—At initial credentialing, 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, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital privileges**—Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI**—Practitioners must have a National Provider Identifier (NPI) issued by the Centers for
- Medicare & Medicaid Services (CMS).

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

Molina will notify the Practitioner immediately in writing if 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 actions, sanctions or exclusions. Molina is not required to reveal the source of information if the information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous
- information and may provide any proof that is available.
- The Practitioner's response must be sent to Molina Healthcare, 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 the Practitioner's information, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within 10 calendar days, their application processing will be discontinued, and network participation will be administratively denied or terminated.

Practitioner's Right to Review Information Submitted to Support their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Molina website and are included in this Provider manual.

The Practitioner must notify the Credentialing department and request an appointment time to review their file and allow up to seven calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

The only items in the file that may be copied by the Practitioner are documents, which the

practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to Be Informed of Application Status

Practitioners have the right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner's rights are published on the Molina website and included in this Provider manual. Molina will respond to the request within two working days. Molina will share with the Practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Molina Medical Director within two weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than 60 calendar days from the decision. Notification of recredentialing approvals are not required.

Recredentialing

Molina recredentials every Practitioner at least every 36 months.

Excluded 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 Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions

Molina monitors the following agencies for Practitioner sanctions and exclusions between

recredentialing cycles for all Practitioner types and takes appropriate action against Practitioners when occurrences of poor quality are identified. If a Molina Practitioner is found to be sanctioned or excluded, the Practitioner's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions program**—Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs
- **State Medicaid exclusions**—Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent)
- **Medicare Exclusion Database (MED)—**Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site
- **Medicare Preclusion List**—Monitor for individuals and entities that are reported on the
- Medicare Preclusion List
- **National Practitioner Database**—Molina enrolls all credentialed Practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles
- **System for Award Management (SAM)**—Monitor for Practitioners sanctioned by SAM.
- Molina also monitors the following for all Practitioner types between the recredentialing cycles.
- Member complaints/grievances
- Adverse events
- Medicare opt out
- Social Security Administration Death Master File

Provider Appeal Rights

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

15. DELEGATION

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

- Utilization management
- Credentialing and recredentialing
- Network administration
- Member/Provider Call Center services

- Sanction monitoring for employees and contracted staff at all levels
- Claims
- Complex care management
- CMS Preclusion List monitoring
- Other clinical and administrative functions

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

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and will be reviewed by Molina delegation oversight staff for compliance with performance expectations within the timeline indicated by Molina.

Corrective Action Plans and Revocation of Delegated Activities

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

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

16. 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 Pharmacists 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 to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting molinahealthcare.com or calling Molina at (800) 424-4518.

Drug Formulary

The pharmacy program does not cover all medications. Molina keeps a list of drugs, devices, and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can get from a pharmacy. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit molinahealthcare.com.

Information on procedures to obtain these medications is described within this document and also available on the Molina website at molinahealthcare.com.

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 safe and appropriate use of the medication.

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.

Step Therapy

Plan restrictions for certain formulary drugs may require that other drugs be tried first. The

formulary designates drugs that may process under the pharmacy benefit without prior authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are not considered as meeting step therapy requirements or as justification for exception requests.

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 service authorization (SA) form. Clinical evidence must be provided and is taken into account when evaluating the request to determine Medical Necessity. The use of manufacturer's samples of non-formulary or "prior authorization required" medications does not override formulary requirements.

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 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 DMAS 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. The following medications are not covered:

1. Drugs used for anorexia or weight gain;
2. Drugs used to promote fertility;
3. Agents whose primary purpose is cosmetic, including but not limited to hair growth. Agents used in the treatment of covered Gender Dysphoria services are not primarily cosmetic;
4. Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;
5. All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered;

6. Drugs which have been recalled;
7. Experimental drugs or non-FDA-approved drugs; and
8. Any legend drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program.

Submitting a Prior Authorization Request

Molina will only process completed service authorization (SA) 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 SA 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 to complete the review. To avoid delays in decisions, be sure to complete the SA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed service authorization form prescription drug to Molina at (844) 278-5731. A blank SA form may be obtained by accessing molinahealthcare.com or by calling (800) 424-4518.

Pharmacy Lock-In

Molina has a Patient Utilization and Safety Management (PUMS) program intended to coordinate care and ensure that Members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS program is a utilization control and care management program designed to promote proper medical management of essential health care.

One component of the PUMS program is pharmacy lock-in. Members considered for inclusion into a lock-in program are identified by data systems; for example, the medical and behavioral health Claims and pharmacy information that will produce a utilization report to identify Members. Members are selected for review based on their behavior patterns and utilization practices compared with other Members of the same population. These Members may have utilized multiple pharmacies, multiple prescribing Providers, multiple controlled substances, multiple emergency visits, a high volume of prescriptions or visits to medical professionals, internal and external referrals that the Member has demonstrated fraudulent or abusive patterns of service utilization, or a previous lock-in enrollment while covered by another plan or Medicaid FFS. Members can also be referred for consideration into the program by their treating Provider.

If a Member is recommended for lock-in, Molina selects a pharmacy based on geographic location and access to pharmacy services and notifies the Member by letter. If the Member wishes to use another pharmacy Provider, the Member must complete and submit a request for reconsideration. The Member also has 60 days to submit an appeal on the lock-in decision. Once locked into a single pharmacy, the Member will be locked in for a period that will not exceed 12 months. At 12 months, the Member will be reviewed to determine if they should remain locked in based on behavior or patterns.

Member and Provider "Patient Safety Notifications"

Molina has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA accredited organization.

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) 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 (HCPCS) via paper or electronic medical Claim 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 Relations 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 Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional opioid-safety and substance use disorder resources at molinahealthcare.com under the Health Resource tab. Please consult with your Provider Services representative or reference the medication formulary for

more information on Molina's Pain Safety Initiatives.

17. LONG TERM SERVICES AND SUPPORT (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) 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.

Virginia Commonwealth Coordinated Care Plus (CCC Plus)

The Virginia Commonwealth Coordinated Care Plus (CCC Plus) Waiver program is a Medicaid program that includes long-term services and supports (LTSS). The LTSS program includes Members who reside in a nursing facility or are receiving community-based services through the CCC plus waiver. Each LTSS Member has an assigned Care Manager who collaborates with and assists the Member with their health care needs. The LTSS program provides an opportunity to create a seamless, integrated health services delivery program.

MLTSS Services and Molina

LTSS Members receive the same benefits as all other Cardinal Care Members. Additionally, the following benefits are available to LTSS Members when the services have been identified as needed by the Molina Care Manager or LTSS Provider.

MLTSS Benefits and Approved Services

Service	Benefit limit	CCC Plus waiver	Tech waiver	Nursing facility
Adult day health care	1 Day = Min of 6 hours	X		
Assistive technology	Max of $5,000 per Member per state fiscal year (July 1 to June 30)	X	X	
Environmental modification (EM)	Max of $5,000 per household per state fiscal year (July 1 to June 30)	X	X	
Hospice	N/A	X	X	X
Long stay hospital	N/A	X	X	
Nursing facility	N/A			X
Personal care	CCC Plus waiver Members: Can receive services through an agency and/or consumer directed; max of 56 hours per week for 52 weeks per year. For those requiring more than 56 hours per week, specific expectation criteria must be met; max limit of 8 hours per day for supervision	X	X	
	Technology dependent waiver Members: Max of 112 hours per week (combination of skilled private duty nursing and personal care hours, but may not be performed at the same time or duplicate any other service received)		X	
Personal Emergency Response System (PERS)—(with or without medication monitoring)	Installation—1 per lifetime monitoring—monthly medication setup—min of every 14 days	X		

Respite care—skilled (can be Member or congregate)	Max of 480 hours per fiscal year (July1 to June 30) Agency directed only		X	
Respite care—unskilled (can be agency and/or consumer directed)	Max of 480 hours per state fiscal year (July 1 to June 30) (combination of agency and consumer direction)	X		
Services facilitation	N/A	X		

Skilled Private Duty Nursing (PDN)—(RN and LPN—can be Member or congregate)	Max 16 hours per day and is reviewed based on Medical Necessity.		X	
Transition coordination	N/A	X	X	X
Transition services	Limited to 1-time cost of $5,000; available within first 30 days of transition to qualified residence.			X

Note: DMAS is solely responsible for the addition or deletion of any service or supply, with the exclusion of the Enhanced Benefits.

Customer-Directed Model of Care & Agency-Directed Model of Care

CCC Plus Members who qualify for the CCC Plus Waiver can receive services such as personal care that assists the Member with their activities of daily living (ADLs) like dressing, bathing, toileting, eating and assistance with self-administration of medication, and Instrumental Activities of Daily Living (IADL) like laundry, food preparation and housekeeping. Respite care services can be skilled or unskilled. Skilled respites services are applicable for someone eligible to receive Private Duty Nursing (via the TECH waiver or EPSDT) and are performed by a nurse through agency directed (AD) care only. Unskilled respite services are applicable for someone eligible to receive Personal Care Services and are performed by the Member's aide. Unskilled respite services can be either consumer directed (CD) or agency directed (AD).

Respite services are utilized for the relief of the unpaid primary caregiver to help ease the physical and emotional stress of providing support and care to the waivered individual. Personal care and respite care services are provided to the Member through CD services, AD services, or, if appropriate, a combination of both. The Care Manager collaborates with the Member to help ensure the delivery of care is appropriate for that Members needs whether it

is through CD or AD services.

AD Services are provided to Members by an in-network agency of their choice. The agency is responsible for providing care and submitting the appropriate forms and documentation that support the need for the requested LTSS services. Once the forms and documentation are received, they will then proceed through the authorization review process. Once a determination has been made, notification is sent to the Provider and Member concerning the authorization request.

If Members elect to receive LTSS services through the CD model of care, they may do so by choosing an in-network service facilitator (SF) to assess their needs, provide training and guidance needed for them or their designee to become an employer of record (EOR). As an EOR, the Member or their identified representative is responsible for hiring, training, supervising and firing attendants. The EOR cannot be the paid attendant caregiver, attendant or SF. The SF is responsible for submitting the appropriate forms and documentation that support the need for LTSS services. Once the forms and documentation has been received, they will then proceed through the authorization review process. Once a determination has been made, notification is sent to the Provider and Member concerning the authorization request.

If the Member has elected CD services, the Fiscal/Employer Agent (F/EA), ACES$, is responsible for establishing accounts for the EOR by securing a federal identification number and establishing the tax accounting process. ACES$ also processes requests for new workers and completes their enrollment, enabling them to be compensated for the CD services they provide. ACES$ processes timesheets and distributes paychecks for all enrolled workers while maintaining accountability for the hours each Member has available for use.

LTSS Authorizations

When Molina reviews authorization requests, we take a multifactorial approach and take into consideration each individual Member's needs. We review and consider the Provider documentation and justification, Member assessments completed by the Care Manager and review of the CCC Plus Provider Manual. Once a determination has been made, a notification letter is sent to the Provider. Molina does not require unskilled home- and community-based services to be ordered by a treating physician, but the Care Manager may consult with the treating physician as appropriate regarding the Member's physical health, behavioral health, and LTSS needs and to facilitate communication and coordination. Skilled home- and community-based services require a physician's order.

For LTSS Members receiving services at home or in the community, the Care Manager collaborates with the LTSS Provider to ensure the appropriate services are in place.