



Medicare Advantage and Prescription Drug Plan
“Molina Medicare Options”
and
Special Needs Plan
“Molina Medicare Options Plus” and “Healthy Advantage”

2009 Provider Manual

Molina Healthcare of Utah

Thank you for your active participation in the delivery of quality health care services to our Members. We look forward to working with you.

This Provider Manual shall serve as an attachment, referenced thereto and incorporated therein, to the Molina Services Agreement/Amendment. The information contained within this Manual is proprietary. The information is not to be copied in whole or part; nor is the information to be distributed without the express written consent of Molina Medicare.

The Provider Manual is a reference tool that contains eligibility, benefits, contact information and policies/procedures for services that Molina Medicare specifically provides and administers on behalf of Molina Medicare health plans.



1404-0209-ALL-UT-PROVMAN

2009 PROVIDER MANUAL

for

Molina Healthcare of Utah, Inc.

Special Needs Plan

“Molina Medicare Options Plus”

and

**Medicare Advantage and Prescription
Drug Plan**

“Molina Medicare Options”

Thank you for your participation in the delivery of quality health care services to our Members. We look forward to working with you.

This Provider Manual shall serve as a supplement, referenced thereto and incorporated therein, to the Molina Services Agreement. In the event of any conflicts within this manual and the one provided regarding Medicaid Members, this supplement takes precedence over matters concerning the care of a Molina Medicare Member.

The information contained within this Manual is proprietary. The information is not to be copied in whole or part; nor is the information to be distributed without the express written consent of Molina Medicare.

The Provider Manual is a reference tool that contains eligibility, benefits, contact information and policies/procedures for services that Molina Medicare specifically provides and administers on behalf of Molina Medicare health plans.

Dear Provider:

I would like to extend a personal welcome to Molina Medicare of Utah. Enclosed is your Molina Medicare Provider Manual, written specifically to address the requirements of delivering health care services to Molina Medicare members.

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

This manual includes samples of forms needed to fulfill your obligations under your Molina Medicare contract. The sample forms are included to illustrate what is needed for appropriate documentation.

From time to time we will need to update and revise this manual as our policies or regulatory requirements change. All changes will be sent to you as additions to or deletions from this manual. You simply need to replace the CD or weblink with a new one.

Thank you for your active participation in the delivery of quality health care services to our members, we look forward to working with you.

Sincerely,

Richard G. Slaughter
Vice President, Molina Medicare

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I. Introduction

Molina Medicare Options Plus and Molina Medicare Options are the brand names of Molina Healthcare, Inc.'s (Molina) Medicare health plans.

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

A. Molina Medicare Options Plus – Special Needs Plan

Molina Medicare **Options Plus** is the name of Molina's Special Needs Plan (SNP), which provides Medicare Advantage and Prescription Drug Benefits. The Options Plus plan was designed for Members who are "dual eligibles" - individuals who are eligible for both Medicare and full Medicaid in order to provide quality healthcare coverage and service with little out-of-pocket costs. Options Plus embraces Molina's longstanding mission to serve those who are the most in need and traditionally have faced barriers to quality health care.

Please contact the Provider Services Department Monday through Sunday from 8:00 a.m. – 8:00 p.m. toll free at **888-665-1328** with questions regarding this program.

B. Molina Medicare Options – Medicare Advantage and Prescription Drug Plan

Molina Medicare Options is the name of Molina's Medicare and Prescription Drug (MAPD) health plan. The Options product offers quality healthcare coverage and service with minimal out-of-pocket costs to Members and enhanced benefits not covered under original Medicare.

Please contact the Provider Services Department Monday through Sunday from 8:00 a.m. – 8:00 p.m. toll free at **888-665-1328** with questions regarding this program.

C. Use of this Manual

From time to time we will need to update and revise this manual as our policies or regulatory requirements change. All changes will be sent to you as additions to or deletions from this manual.

This manual contains samples of the forms needed to fulfill your obligations under your Molina contract. If you are already using forms that accomplish the same goals, you may not need to modify them. Sample forms are included in the back of this manual to illustrate what is needed for appropriate documentation.

II. Background and Overview of Molina Healthcare, Inc. (Molina)

Molina, headquartered in Long Beach, California, is a multi-state managed care company focused on providing healthcare services to people who receive healthcare benefits through government-sponsored programs.

C. David Molina, M.D., founded our company in 1980 as a Provider organization with a network of primary care clinics in California, twenty-one of which are in operation. As the need for more effective management and delivery of healthcare services to underserved populations continued to grow, Molina became licensed as a Health Maintenance Organization (HMO) in California.

Included in Molina Provider networks are company-owned and operated primary care clinics, independent physicians and medical groups, hospitals and ancillary Providers.

Today, the Company provides healthcare services in California, Florida, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, Virginia and Washington and has nearly 1.3 million Members.

A. Mission, Vision and Core Values

Our mission is to promote health and provide health services to families and individuals who traditionally have faced barriers to quality health, have lower income and are covered by government programs.

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

Core Values:

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

B. Significant Growth of Molina

Since 2001, Molina Healthcare, Inc, a publicly traded company (NYSE: MOH), has achieved significant Member growth through internal growth initiatives and acquisitions of other health plans. We believe that our strong financial and operational performance is uniquely attributable to the recognition and understanding that our Members have distinct social and medical needs, and are characterized by their cultural, ethnic and linguistic diversity.

Since our inception nearly 30 years ago, we have designed our company to work with government agencies to serve low-income and special needs populations. Our success has resulted from:

- expertise in working with federal and state government agencies;
- extensive experience in meeting the needs of our Members;
- owning and operating primary care clinics;
- cultural and linguistic expertise; and
- a focus on operational and administrative efficiency.

C. The Benefit of Experience

Beginning with our primary care clinics in California, our company grew up in the neighborhoods where our Members live and work. Our early experience impressed upon our management the critical importance of community-based patient education to the goal of cost-effective healthcare management. We promote greater access to the entire continuum of care, particularly at the times when it can do the greatest good.

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

D. Administrative Efficiency

The Company operates its business on a centralized platform that standardizes various functions and practices across all of its health plans in order to increase administrative efficiency. Each state licensed subsidiary contracts with Molina, Inc. (MHI) for specific centralized management, marketing, and administrative services.

E. Quality

As we strive for greater efficiency, we do not compromise the quality of medical care delivered to our Members. Our company is committed to quality and has made accreditation a strategic goal for each of Molina's health plans. Year after year, our health plans have received accreditation from the National Committee for Quality Assurance (NCQA). The NCQA accreditation process sets the industry standard for quality in health plan operations.

F. Flexible Care Delivery Systems

Molina has constructed its systems for healthcare delivery to be readily adaptable to different markets and changing conditions. Healthcare services are arranged through contracts with Providers that include Molina-owned clinics (in California and Virginia only), independent physicians and medical groups, hospitals and ancillary Providers. The company's systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates and diagnostic-related groups (DRGs).

G. Cultural and Linguistic Expertise

National census data shows that the population is becoming increasingly diverse. We have a nearly 30 year history of developing targeted healthcare programs for our culturally diverse Membership and believe we are well-positioned to successfully serve these growing populations. We contract with a diverse network of community-oriented Providers who have the capabilities to address the linguistic and cultural needs of our Members. We have established cultural advisory committees in all of our major markets. We educate our employees about the differing needs among our Members. We develop Member education material in a variety of media and languages and ensure that the literacy level is appropriate for our target audience.

H. Member Marketing and Outreach

Member marketing is focused on creating an awareness of Molina as an option for Medicare-eligible beneficiaries including those who are Full Benefit Dual Eligible beneficiaries. Member marketing relies heavily on community outreach efforts. Resources are supplied to community agencies serving the targeted population. Sales agents, brochures, billboards and other methods are also used within the Centers for Medicare & Medicaid Services (CMS) marketing guidelines.

III. Contact Information for Providers - Molina Medicare of Utah

Molina Medicare of Utah
 7050 Union Park Center, Suite 200
 Midvale, Utah 48047

Providers please note: Some Molina Medicare functions are located in other states.

24 HOUR NURSE ADVICE LINE FOR MOLINA MEDICARE MEMBERS		
Services available in English and in Spanish.	Toll Free English Phone	888-275-8750
	Toll Free Spanish Phone	866-648-3537
	Hearing Impaired (TTY/TDD)	866-735-2922
CLAIMS, TRACERS, CLAIMS APPEALS		
Mailing Address: Molina Medicare Options Option Plus Claims PO Box 22801 Long Beach, CA 90801 Physical Address - to send overnight packages: Molina Medicare One Golden Shore Long Beach, CA 90802	Toll Free Phone	888-665-1328
	Hearing Impaired (TTY/TDD)	800-346-4128
COMPLIANCE/ANTI-FRAUD HOTLINE		
Mailing Address:	24/7 Toll Free Phone	866-421-8090
	Fax	866-472-0602
CREDENTIALING		
Mailing Address: Molina Medicare of Utah Credentialing Department 7050 Union Park Center, Suite 200 Midvale, Utah 48047	Toll Free Phone	888-665-1328
	Hearing Impaired (TTY/TDD)	800-346-4128
	Direct Line	801-858-0400 Ask for Provider Services

ELIGIBILITY – PROVIDER AND MEMBER SERVICES		
Mailing Address: Molina Medicare 7050 Union Park Center, Suite 200 Midvale, Utah 48047	Toll Free Phone	888-665-1328
	Hearing Impaired (TTY/TDD)	800-346-4128
	Fax	801-858-0409
QUALITY IMPROVEMENT		
Mailing Address: Molina Medicare of Utah Quality Improvement Department 7050 Union Park Center, Suite 200 Midvale, Utah 48047	Toll Free Phone	888-665-1328
	Hearing Impaired (TTY/TDD)	800-346-4128
	Fax	801-858-0409
UTILIZATION MANAGEMENT, REFERRALS & AUTHORIZATION		
Molina Medicare 7050 Union Park Center, Suite 200 Midvale, Utah 48047	Toll Free Phone	888-483-0760
	Hearing Impaired (TTY/TDD)	800-346-4128
	Fax	866-472-0589

IV. Eligibility and Enrollment in Molina Medicare Plans

A. Members who wish to enroll in Molina Medicare Options Plus, a Medicare Advantage-Prescription Drug Special Needs Plan (SNP), must meet the following criteria:

- Be entitled to and enrolled in both Medicare Part A and Part B.
- Not be medically determined to have ESRD prior to completing the enrollment form (unless individual is an existing Medicaid Member).
- Permanently reside in the Molina Medicare service area, which includes the following counties in 2009: Davis, Iron, Salt Lake, Utah, Washington and Weber.
- Beneficiary or beneficiary's legal representative completes an enrollment election form completely and accurately.
- Beneficiary is fully informed and agrees to abide by the rules of Molina Medicare.
- Is entitled to elect Molina Medicare according to the election rules that apply to the beneficiary.
- Is entitled to Full Medicaid benefits as defined by the State.

Further,

- Molina Medicare will not deny enrollment to a beneficiary who has elected the hospice benefit if the individual meets the other criteria for enrollment.
- Molina Medicare will accept all Members that meet the above criteria and elect Molina Medicare during appropriate enrollment periods.

B. Members who wish to enroll in Molina Medicare Options, a Medicare and Prescription Drug Plan (MAPD), must meet the following criteria:

- Be entitled to and enrolled in both Medicare Part A and Part B.
- Not be medically determined to have ESRD prior to completing the enrollment form (unless individual is an existing Medicaid Member).
- Permanently reside in the Molina Medicare service area, which includes the following counties in 2009: Davis, Iron, Salt Lake, Utah, Washington and Weber.
- Beneficiary or beneficiary's legal representative completes an enrollment election form completely and accurately.
- Beneficiary is fully informed and agrees to abide by the rules of Molina Medicare.
- Is entitled to elect Molina Medicare according to the election rules that apply to the beneficiary.
- During the Annual Enrollment Period (AEP), must apply between November 15 through December 31 and for the Open Enrollment Period (OEP), must apply from January 1 through March 31. Otherwise members must have a Special Election Period (SEP) in order to qualify for Options (Molina Medicare Options plan). Qualifications for the SEP are:
 - Aged in - member turns 65
 - Qualifies for Low Income Subsidy
 - Partial Medicaid defined as Qualified Medicare Beneficiary and Specified Low Income Medicare Beneficiary
 - Employer Group Health Plan enrollee
 - Loss of full dual eligible or Special Need Plan Status
 - Loss of Medicaid

- Change of residence

Further,

- Molina Medicare will not deny enrollment to a beneficiary who has elected the hospice benefit if the individual meets the other criteria for enrollment.
- Molina Medicare will accept all Members that meet the above criteria and elect Molina Medicare during appropriate enrollment periods.

C. Beneficiary Enrollment/Disenrollment Information

1. All Members of **Molina Medicare Options Plus** are full benefit dual eligibles (i.e. they receive both Medicare and Medicaid); therefore, CMS rules state that these Members may enroll or disenroll **on a monthly basis**.
2. Enrollment in **Molina Medicare Options** is limited to the following enrollment periods determined by CMS:
 - Annual Election Period: November 15th through December 31st each year. Enrollment elections made during the Annual Election Period will be effective January 1st of the following year.
 - Open Enrollment Period: January 1st – March 31st each year. During this period, a Member may chose to change Medicare programs. If a Member elects to change to a new Medicare program, the change is effective the first day of the following month.
 - Member elections during Open Enrollment are limited. Elections must be made to the same type of plan in which the individual is already enrolled in. For example, if a Member is enrolled in a Medicare plan that *does not* provide part D coverage, they may not enroll in a plan that offers Part D coverage during Open Enrollment.
 - Initial Coverage Election Period: This election period is limited to individuals who **are newly eligible** for enrollment in a Medicare plan. In general, newly eligible individuals have a seven month window that opens three months before and individual meets eligibility requirements and ends three months after the month of eligibility.
 - CMS also allows Special Election Periods in certain circumstances. Unlike our Options Plus plan, not all Molina Medicare Options Members may elect a new plan every month and will remain in our Option plan until the next election period.

D. Prospective Members Toll Free Telephone Numbers

Prospective Members may call Molina Medicare at **866-403-8293** or **800-346-4128** for persons with hearing impairments (TTY/TDD) for further information and enrollment forms.

E. Effective Date of Coverage

The effective date of coverage for Members will be the first day of the month following the acceptance of a complete Enrollment form signed by the Member or the Member's authorized representative.

An enrollment cannot be effective prior to the date the beneficiary or their legal representative signed the enrollment form or completed the enrollment election. During the applicable enrollment periods, if Molina Medicare receives a completed enrollment form on the last day of

the month, Molina Medicare ensures that the effective date is the first day of the following month.

F. Disenrollment

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

- permanently moved outside the geographic service area
- committed fraud
- abused their Membership card
- displayed disruptive behavior
- lost Medicare Part A or B.

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

- Out-of-area notification will be received from CMS on the monthly Membership report
- The Member may call to advise Molina Medicare that they have relocated.
- Other means of notification can be made through the Claims Department, if out-of-area claims are received with a residential address other than the one on file.

Molina Medicare does not offer a visitor/traveler program to Members.

G. Requested Disenrollment

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

- The Member requests disenrollment.
- The Member provided fraudulent information on the election form.
- The Member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan Members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Other reasons for the disenrollment may be one of the following:

- The Member abuses the enrollment card by allowing others to use it to obtain fraudulent services.
- The Member leaves the service area and directly notifies Molina Medicare of the permanent change of residence.
- If the Member has not permanently moved but has been out of the service area for 6 months or more, Molina Medicare will request that the Member be disenrolled.
- The Member loses entitlement to Medicare Part A or Part B benefits.
- The Member loses Medicaid eligibility.

- Molina Medicare loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina Medicare will send CMS approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely, before the termination of the plan.
- Molina Medicare discontinues offering services in specific service areas where the Member resides.

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

H. Eligibility List Distribution and Updates

Molina Medicare receives its Member eligibility information on a monthly basis from CMS and is then distributed via an Eligibility list (E-list) to its contracted PCPs and medical groups. At times, due to retroactive enrollment or PCP assignment, Member information is not included on the E-lists.

I. For Capitated Providers: Eligibility Discrepancy

When a Provider has identified that a discrepancy exists with a Member's eligibility status, assignment or payment, the PCP or medical group may submit any of the following information for review:

- Confirmation of Member eligibility
- Copy of Member eligibility from Molina Medicare (i.e. Member ID card identifying a specific PCP, E-list)
- Payment discrepancy (copy of payment denial must be attached)
- Brief explanation of the matter

Molina Medicare staff researches and resolves the matter within five business days of its receipt and will notify the contact person of the resolution. Any corrections to the Member's eligibility status are made in the required systems by Molina Medicare staff. If a payment adjustment is required, a copy of the determination is forwarded to the Financial Department for review and appropriate action. Depending on the issue involved, other affected Molina Medicare departments may be provided copies of the determination as well.

- If a Member's eligibility is verified but the Member's name does not appear on the current month's E-List, services should not be denied; however the PCP or Provider should contact Molina Medicare's Medicare Provider Services Department prior to rendering service to verify PCP assignment.
- If a Member's name appears on the current month's E-list but the Member is not eligible with the health plan, services should not be denied; however the PCP or Provider should contact Molina Medicare's Medicare Provider Services Department prior to rendering service to verify the Member's eligibility.
- Providers must always verify a Member's eligibility. If a PCP or other Provider renders a service to a Member who is not assigned to them, they must contact the Molina Medicare Provider Services Department and explain the situation to receive proper payment for



services. The Provider Services Representative records the circumstances related to the service and forwards documentation to the appropriate department for processing.

Failure to verify eligibility prior to rendering services could result in denial of payment. The PCP, medical group or other Provider must create, maintain and provide to the Medicare Provider Services Department upon request a tracking log that reflects Member eligibility verification at the time service is rendered.

Providers whose claim for services rendered is denied may file a formal complaint and/or appeal with Molina Medicare.

Please see examples and explanations of Member Eligibility files. Eligibility lists may be distributed to the PCP directly by Molina Medicare or by the delegated medical group or IPA that holds the contract.

J. Member Identification Card Example

MOLINA MEDICARE OPTIONS PLUS UTAH		
Member:		
Member #	Date of Birth:	Effective Date:
<hr/>		
Primary Care Provider:		
Primary Care Provider Phone:		
Medical Group:		
RxGroup:		
RxCopay: \$0 Generic/\$3.20 Brand		
RxBIN: 012189	RxPCN: 5002	
Issue ID:	Issued Date:	H5628-001

<p>This card is for identification purpose only and does not prove eligibility for services.</p> <p>Members: Please show this card when you receive healthcare services. In case of emergency, call 911 or go to the nearest emergency room. No prior authorization is required for emergency care. Please contact Molina Medicare within 48 hours of receiving emergency services. If you have any questions, please call:</p> <p>Member Service Number: 1-888-665-1328 24-Hour Nurse Advice Line: 1-888-275-8750 TTY for Member Services: 1-800-346-4128 TTY for Nurse Advice Line: 1-866-735-2922 Hours of Operation: 8AM-8PM Monday-Sunday local time.</p> <p>Providers/Hospitals: Notify Molina Medicare with In 24 hours of any inpatient admission. For prior authorization, eligibility and general information, please call Molina Medicare at 1-888-665-1328 or TTY at 1-800-346-4128 from 8AM-5PM Monday-Friday, local time or any time after hours at 1-888-275-8750, the TTY is 1-866-735-2922.</p> <p>Claim Submission Information: Medical/Hospital: Molina Healthcare, PO Box 22811, Long Beach, CA 90801 Pharmacy: 7050 S Union Park Ave, Suite 200, Midvale, Utah 84047</p> <p>www.molinahealthcare.com</p>
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K. Verifying Eligibility

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

V. Benefit Overview

A. Billing Members

Providers who participate with Molina Medicare health plans agree to accept the amount paid as payment in full (see 42 CRF 447.15) with the exception of copayment amounts required in certain categories. Copayments are outlined in this section.

Aside from copayments, a Provider may not bill a Molina Medicare Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:

- The Member has been advised by the Provider that the service is not a covered benefit and the provider has documentation.
- The Member has been advised by the Provider that he/she is not contracted with Molina Medicare and has documentation.
- The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.
- Denied emergency room claims: A Member is responsible for payment of a hospital outpatient emergency room visit if it is determined that an emergency did not exist at the time the service was provided except in those circumstances in which the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of medical attention could reasonably be expected by a prudent layperson to result in placing the Member's health in jeopardy, impairment or dysfunction. The Member may only be billed for the emergency room charges, but cannot be billed for the ancillary charges (e.g., laboratory & radiology services).

B. Benefit Overview

The following is a summary of the Molina Medicare Options Plus and Molina Medicare Options benefits. If there are questions as to whether a service is covered or requires prior authorization, contact Provider Services at **1-888-665-1328** or **800-346-4128** for persons with hearing impairments (TTY/TDD).

Molina Medicare Options Plus Benefits	You Pay
Monthly Health Plan Premium	\$0
Annual In-network Out-of-Pocket Maximum	\$0
Doctor Office Visits:	
• Primary Care Physician	\$0
• Specialist	\$0
Inpatient Hospitalization Care	\$0
Inpatient Mental Care Health	\$0
Skilled Nursing Facility	\$0
Outpatient Mental Health Care and Substance Abuse	\$0 per individual or group visit
Outpatient Hospital and Ambulatory Surgical Center Services	\$0 per visit
Emergency Care	\$0
Urgently Needed Care	\$0 in area network

Ambulance Services (one-way trip)	\$0
Prescription Drug Copays ¹ <ul style="list-style-type: none"> • Tier 1 – Generic • Tier 2 – All other drugs 	\$0 or \$1.10 or \$2.40 \$0 or \$3.20 or \$6
Outpatient Rehabilitation Services (physical, occupational, speech & language therapy)	\$0
Durable Medical Equipment	0%
Prosthetic Devices	0%
Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies	0%
Outpatient Diagnostic Tests, X-ray and Lab Services	\$0
Outpatient Diagnostic and Therapeutic Radiology Services	\$0
Annual Routine Physical Exam	\$0
Immunizations (Includes Pneumococcal Pneumonia, Flu and Hepatitis B Vaccines)	\$0
Preventive Screenings (in addition to annual screening exams covered by Medicare) <ul style="list-style-type: none"> ▪ Pap Smears ▪ Pelvic Exams ▪ Prostate Screening ▪ Colorectal Screening ▪ Screening Mammograms <i>(Office visit copayment may apply.)</i>	\$0; one per year \$0; one per year \$0; one per year \$0; one every 3 years \$0; one per year
Comprehensive Dental Services: (emergency, diagnostic, restorative, endodontics, periodontics and extractions)	\$0; \$1,800 limit per year
Hearing Services <ul style="list-style-type: none"> ▪ Annual Routine Hearing Test ▪ Fitting for Hearing Aids ▪ Hearing Aid Allowance 	\$0 \$0; once every 5 years \$1,500 limit every 5 years
Vision Services <ul style="list-style-type: none"> ▪ Annual Routine Eye Exam ▪ Eye wear allowance (includes glasses, contacts, lenses, frames and upgrades) 	\$0 \$300 limit every 2 years
Routine Podiatry Services	\$0 per visit; 12 visits per year
Routine Transportation to & from medical appointments	\$0; 48 one-way trips per year
Over-the-Counter Medications & Supplies	\$25 allowance per month for pre-selected catalogue items
Emergency Medical Response	\$0 for set up and monthly monitoring
24-Hour Nurseline	\$0
Health and Wellness Education	\$0
Smoking Cessation	\$0

¹ Copayments are based on your income and institutional status. After your total yearly out-of-pocket costs reach \$4,350, you pay nothing. For details on Prescription Drug benefits, refer to the Summary of Benefits. For information on Low Income Subsidy qualifications, contact Member Services.

Molina Medicare Options Benefits	You Pay
Monthly Health Plan Premium ¹	\$29
Annual In-network Out-of-Pocket Maximum	\$3,350
Doctor Office Visits: <ul style="list-style-type: none"> • Primary Care Physician • Specialist 	\$15 \$25
Inpatient Hospitalization Care	\$150 per day for days 1-5; \$0 per day for days 6-90; not covered for days 91-150
Inpatient Mental Health Care	\$300 per day for days 1-5; \$0 per day for days 6-90; not covered for days 91-280
Skilled Nursing Facility	\$0 per day for days 1-10; \$150 per day for days 11-100 \$2,500 out-of-pocket max
Outpatient Mental Health Care	\$35 per individual or group visit
Outpatient Substance Abuse	\$40 per individual or group visit
Outpatient Hospital Services	\$100 per visit
Outpatient Ambulatory Surgical Center Services	\$75 per visit
Emergency Care	\$50
Urgently Needed Care	\$35 in area network
Ambulance Services (one-way trip)	\$100
Prescription Drug (for 30/90 day supply) ² <ul style="list-style-type: none"> ▪ Tier 1 - Generic ▪ Tier 2 - Preferred Brand ▪ Tier 3 - Non-Preferred]Brand ▪ Tier 4 - Specialty 	\$5/15 \$20/\$60 \$50/\$150 33%/33%
Outpatient Rehabilitation Services (physical, occupational, speech & language therapy)	\$30 per visit
Durable Medical Equipment	20%
Prosthetic Devices	20%
Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies	20%
Outpatient Diagnostic Tests, X-ray and Lab Services	\$0
Outpatient Diagnostic and Therapeutic Radiology Services	\$100
Annual Routine Physical Exam	\$0
Immunizations (Includes Pneumococcal	\$0

Pneumonia, Flu and Hepatitis B Vaccines) (Office visit copayment may apply.)	
Preventive Screenings (in addition to annual screening exams covered by Medicare) <ul style="list-style-type: none"> ▪ Pap Smears ▪ Pelvic Exams ▪ Prostate Screening ▪ Colorectal Screening ▪ Screening Mammograms] (Office visit copayment may apply.)	<p>\$0; one per year</p> <p>\$0; one per year</p> <p>\$0; one per year</p> <p>\$0; one every 3 years</p> <p>\$0; one per year</p>
Dental Services Preventive Dental Services: <ul style="list-style-type: none"> • Two oral exams per year • Two cleanings per year • Two fluoride treatments per year • Two X-rays per year Comprehensive Dental Services: (emergency, diagnostic, restorative, endodontics, periodontics and extractions)	<p>\$15</p> <p>40%; \$1,200 limit per year</p>
Hearing Services <ul style="list-style-type: none"> ▪ Routine Hearing Test ▪ Fitting for Hearing Aids ▪ Hearing Aid Allowance 	<p>\$15; one every 2 years</p> <p>\$0; once every 5 years</p> <p>40%; \$1,500 limit every 5 years</p>
Vision Services <ul style="list-style-type: none"> ▪ Annual Routine Eye Exam ▪ Eye wear allowance (includes glasses, contacts, lenses, frames and upgrades) 	<p>\$15</p> <p>\$300 every 2 years</p>
Over-the-Counter Medications & Supplies	\$19 allowance per month for pre-selected catalogue items
24-Hour Nurseline	\$0
Health and Wellness Education	\$0
Smoking Cessation	\$0

¹You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.

²Copayments represent the amount paid before yearly drug costs paid by you and the plan reach \$2,700. At that point, you pay 100% of your drug costs. After your total yearly out-of-pocket costs reach \$4,350, you pay a different copayment depending on the drug tier. For details on Prescription Drug benefits, refer to the Summary of Benefits. For information on Low Income Subsidy qualifications, contact Member Services.

VI. Quality Improvement

Molina Medicare maintains a Quality Improvement (QI) Department to work with members and providers in administering the Molina Medicare Quality Improvement Program. You can contact the Molina Medicare QI Department for your state by phone at **888-665-1328** or fax **801-858-0409**

The address for mail requests is:

**Molina Medicare of Utah
Quality Improvement Department
7050 Union Park Center, Suite 200
Midvale, Utah 48047**

This provider manual contains excerpts from the Molina Medicare Quality Improvement Program Description (QIPD). For a complete copy Molina Medicare of Utah's QIPD you can contact your Provider Services representative or call the phone number above to receive a written copy.

Molina Medicare has established a Quality Improvement (QI) Program that complies with regulatory and accrediting guidelines such as the National Committee for Quality Assurance (NCQA). The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service and health of our Members.

Molina Medicare does not delegate Quality Improvement activities to Medical Groups/IPAs. However, Molina Medicare requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care and to:

- Have a quality improvement program in place.
- Comply with and participate in Molina Medicare's Quality Improvement Program including reporting of Access and Availability and provision of medical records as part of the HEDIS® review process.
- Allow access to Molina Medicare QI personnel for site and medical record review processes.

A. Medical Records

Molina Medicare 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. Molina Medicare conducts a medical record review of Primary Care Physician (PCPs) every three years that includes the following components:

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

Providers must demonstrate compliance with Molina Medicare's medical record documentation guidelines. Medical records are assessed based on the following standards:

1. Content:

- Patient name or ID is on all pages.
- Current biographical data is maintained in the medical record or database.
- All entries contain author identification.
- All entries are dated.
- Medication allergies and adverse reactions are prominently displayed. Absence of allergies is noted in easily recognizable location.
- Chronic conditions are listed or noted in easily recognizable location.
- Past medical history for patients seen more than 3 times is noted.
- Consistent charting of treatment care plan.
- Treatment plans are consistent with diagnoses.
- Encounter notation includes follow up care, call, or return instructions.
- Preventive health measures (i.e., immunizations, mammograms, etc.) are noted.
- A system is in place to document telephone contacts.
- Lab and other studies are ordered as appropriate.
- Lab and other studies are initialed by ordering Provider upon review.
- Lab results and other studies are filed in chart.
- If patient was referred for consult, therapy, or ancillary service, a report or notation of result is noted at subsequent visit, or filed in medical record.
- If the Provider admitted a patient to the hospital in the past 12 months, the discharge summary must be filed in the medical record.

• **2. 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.

3. Retrieval:

- Medical record is available to Provider at each encounter
- Medical record is available to MCO for purposes of quality improvement
- Medical record retention process is consistent with state and federal requirements
- Data recovery procedure functions in the event of data loss

4. Confidentiality:

- 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

Additional information on medical records is available from your local Molina Medicare QI Department with the phone contact number listed above. See also Section VII regarding the Health Insurance Portability and Accountability Act (HIPAA).

B. Access to Care

Molina Medicare is committed to timely access to care for all Members in a safe and healthy environment. 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.

1. Appointment Access

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

Primary Care Physician (PCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Emergency Care	Immediate
Acute Care	Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP office.
Preventive Care Appointment	Within 6 weeks of request
Routine Primary Care	Within 6 weeks of request
After Hours Care	After-Hours Instruction/Standards
After hours emergency instruction	If this is an emergency, please hang up and dial 911
After-Hours Care	Available by phone 24 hours/7 days
Specialty Care Physician (SCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Routine Care	Within 8 weeks of request
Pregnancy (for initial visit)	Within 2-6 weeks of request
Behavioral Health	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Non-life Threatening Emergency Care	Within ≤ 6 hours of request
Urgent Care	Within ≤ 48 hours of request
Routine Care	Within ≤ 10 working days of request

Additional information on appointment access standards is available from your local Molina Medicare QI Department with the phone contact number listed above.

2. Office Wait Time

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

3. After Hours

All physicians must have back-up (on call) coverage after hours or during the physician's absence or unavailability. Molina Medicare requires physicians to maintain a 24 hour phone service, 7 days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an emergency to hang-up and call 911 or go immediately to the nearest emergency room. After hours phone calls or pages must be returned within 30 minutes.

4. Appointment Scheduling

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

- The physician 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.
- 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 physician 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 physician is to notify the Molina Medicare Member Services Department at **888-665-1328 or TTY/TDD 800-346-4128**.
- When the physician must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time.
- Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-bound Members and Members requiring language translation.
- A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms.
- 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, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits.

Additionally, a participating Provider or contracted medical group/IPA may not limit his/her practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If a PCP chooses to close his/her panel to new Members, Molina must receive 30 days advance written notice from the Provider.

5. Monitoring Access for Compliance with Standards

Molina Medicare monitors compliance with the established access standards above. At least annually, Molina Medicare conducts a telephone access survey of randomly selected contracted Provider offices to determine if appointment access standards are met. One or all of the following appointment scenarios may be addressed: routine care; acute care; preventive care; and after hours information. Results of the survey are distributed to the Providers after its completion. A corrective action plan may be required if standards are not met.

In addition, Molina Medicare's Member Services Department reviews Member inquiry logs and grievances related to delays in access to care. These are reported quarterly to committees. Delays in access that may create a potential quality issue are sent to the Quality Improvement (QI) Department for review.

Additional information on access to care is available under the Resources tab available from your local Molina Medicare QI Department with the phone contact number listed above.

C. Advance Directives (Patient Self-Determination Act)

Providers must inform patients of their right to make health care decisions and execute advance directives. It is important that Members are informed about advance directives. During routine Medical Record review, Molina Medicare auditors will look for documented evidence of discussion between the Provider and the Member. Auditors will also look for copies of the advance directive form. Advance Directives forms are state specific to meet state regulations.

For a copy of forms applicable to your state please go to <http://www.uslivingwillregistry.com/forms.shtm> to view forms available for download.

Advance Directives are a written choice made by a Member for health care treatment. There are two kinds of directives – Durable Power of Attorney for Health Care and Directive to Physicians. Written Advance Directives tell the Primary Care Physician (PCP) and other medical Providers how Members choose to receive medical care in the event that they are unable to make end-of-life decisions.

Each Molina Medicare Provider must honor Advance Directives to the fullest extent permitted under law. PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance. 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. Medicare law gives Members the right to file a complaint with Molina Medicare or the state survey and certification agency if the Member is dissatisfied with Molina Medicare's handling of Advance Directives and/or if a Provider fails to comply with advance directive instructions.

Durable Power of Attorney for Health Care: This Advance Directive names another person to make medical decisions on behalf of the Member when they cannot make the choices for themselves. It can include plans about the care a Member wants or doesn't want and includes

information concerning artificial life-support machines and organ donations. This form must be signed, dated and witnessed by a notary public to be valid.

Directive to Physicians (Living Will): This Advance Directive usually states that the Member wants to die naturally without life-prolonging care and can also include information about any desired medical care. The form would be used if the Member could not speak and death would occur soon. This directive must be signed, dated and witnessed by two (2) people who know the Member well but are not relatives, possible heirs, or health care Providers.

When There Is No Advance Directive: The Member’s family and doctor 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.

D. Quality Improvement Activities and Programs

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

1. Health Management/Disease Management Programs

Molina Medicare has established health management programs to measure and improve health status and quality of life. The Health Management Programs involve a collaborative team approach comprised of health education, clinical case management and Provider education. The team works closely with contracted Providers in the identification, assessment and implementation of appropriate interventions. Currently these programs are made available to all eligible Molina Medicare Members based on inclusion criteria, and to all network Providers.

Breathe with Ease SM for Asthma	
Healthy Living with Diabetes SM	Smoking Cessation
Chronic Obstructive Pulmonary Disease (COPD)	Medication Therapy Management
Cardiovascular Disease SM	

a. Program Eligibility Criteria and Referral Source

Health Management Programs are designed for active Molina Medicare Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan’s coverage or until the Member opts out. Each identified Member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified Members will receive regular educational newsletters. The program model provides an “opt-out” option for Members who contact Molina Medicare Member Services and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These include the following:

- Pharmacy claims data for all classifications of medications

- Encounter data or paid claim with a relevant CPT or ICD-9 code
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- Provider referral
- Medical Case Management or Utilization Management
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication.

b. Provider Participation

Contracted Providers are automatically notified whenever their patients are enrolled in a health management program. Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease
- Clinical resources such as patient assessment forms and diagnostic tools
- Patient education resources such as booklets, magnets, CDs, DVDs, etc.
- Provider Newsletter with disease specific articles
- Clinical Practice Guidelines
- Preventive Health Guidelines

Additional information on health management/disease management programs is available from your local Molina Medicare QI Department with the phone contact number listed above.

2. Clinical Practice Guidelines

Molina Medicare adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriate established authority. Clinical Practice Guidelines are reviewed annually and are updated as new recommendations are published.

Molina Medicare Clinical Practice Guidelines include the following:

Asthma	Hypertension
Depression	Diabetes
Chronic Obstructive Pulmonary Disease	Coronary Heart Disease
Cholesterol Management	

The adopted Clinical Practice Guidelines are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality Improvement, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through physician newsletters, Just the Fax electronic bulletins and other media and are available on the Molina Medicare Website. Individual Providers or Members may request copies from your local Molina Medicare QI Department with the phone contact number listed above.

3. Preventive Health Guidelines

Molina Medicare provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with CMS guidelines. Diagnostic preventive procedures include but are not limited to:

- Mammography Screening
- Screening pap smear
- Pelvic examination
- Breast examination
- Prostate cancer screening
- Cholesterol screening
- Colorectal screening
- Influenza, pneumococcal and hepatitis vaccines

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to Providers via www.molinamedicare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Medicare Provider Newsletter.

4. Cultural and Linguistic Services

Molina Medicare serves a diverse population of Members with specific cultural needs and preferences. Providers are responsible to ensure that interpreter services are made available at no cost for Members with sensory impairment and/or who are Limited English Proficient (LEP). The following cultural and linguistic services are offered by Molina Medicare to assist both Members and Providers.

a. 24 Hour Access to Interpreter

Providers may request interpreters for Members whose primary language is other than English by calling Molina Medicare's Member Services Department at **866-440-0127**. If Member Services representatives are unable to provide the interpretation services internally, the Member and Provider are immediately connected to Language Line telephonic interpreter service.

If a patient insists on using a family Member as an interpreter after being notified of his or her right to have a qualified interpreter at no cost, document this in the Member's medical record. Molina Medicare is available to assist you in notifying Members of their right to an interpreter. All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done via interpreter services. Providers should document who provided the interpretation service. That information could be the name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreter's name, operator code number and vendor.

b. Face-to-Face Interpretation

Providers may request face-to-face interpretation for scheduled medical visits, if required, due to the complexity of information exchange or when requested by the Member. To request face-to-face interpretation services, please contact the Health Education Department. Additional information on cultural and linguistic services is available at www.molinamedicare.com from your local Provider Services representatives and from the Molina Medicare Member Services Department.

E. Measurement of Clinical and Service Quality

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

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

Molina Medicare’s most recent results can be obtained from your local Molina Medicare QI Department with the phone contact number listed above.

1. HEDIS®

Molina Medicare 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, appropriate use of asthma medications and prenatal and postpartum care.

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

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to establish health plan performance benchmarks and are an integral part of the NCQA© health plan accreditation process.

2. CAHPS®

CAHPS® is the tool used by Molina Medicare to summarize Member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Promotion and Education, Coordination of Care and Customer Service. The CAHPS® survey is administered annually in the spring to randomly selected Members by a 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 Medicare's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

3. Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on Member experience with health care Providers and health plans, Molina Medicare conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina Medicare, as this is one of the primary methods we use to identify improvement areas pertaining to the Provider network. The survey results have helped establish improvement activities relating to Molina Medicare'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.

4. Effectiveness of Quality Improvement Initiatives

Molina Medicare 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.

VII. The Health Insurance Portability and Accountability Act (HIPAA)

A. Molina Medicare's Commitment to Patient Privacy

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

B. Provider Responsibilities

Molina Medicare expects that its contracted Providers will respect the privacy of Molina Medicare members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

C. Applicable Laws

Providers must understand all state and federal healthcare privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that Providers must comply with. In general, most State healthcare 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
 - Medicare and Medicaid laws
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.

D. Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own *treatment, payment, and healthcare operations* activities (TPO) without the consent or authorization of the patient who is the subject of the PHI.

Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity. (See, Sections 164.506(c)(2) & (3) of the HIPAA Privacy Rule.) Disclosure of PHI by one covered entity to another covered entity, or healthcare provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as

preauthorization of services, concurrent review, and retrospective review of “services.” (See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule)

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
 - Quality improvement;
 - Disease management;
 - Case management and care coordination;
 - Training Programs; or
 - Accreditation, licensing, and credentialing

Importantly, this allows Providers to share PHI with Molina for our healthcare operations activities, such as HEDIS and quality improvement.

E. Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

F. Patient Rights

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

1. Notice of Privacy Practices - Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient’s privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.
2. Requests for Restrictions on Uses and Disclosures of PHI - Patients may request that a healthcare Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.
3. Requests for Confidential Communications - Patients may request that a healthcare Provider 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 both the patient’s medical record, as well as billing and other records used to make decisions about the member’s care or payment for care.

5. Request to Amend PHI - Patients have a right to request that the Provider amend information in their designated record set.
6. Request Accounting of PHI Disclosures - Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

G. HIPAA Security

Providers should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

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

H. HIPAA Transactions and Code Sets

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

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

Molina Medicare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina should refer to

<http://www.molinahealthcare.com/medicaid/providers/common/edi/home.html?state=ut>

I. National Provider Identifier

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina Medicare 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 Medicare within 30 days of the change. Provider must use their NPI to identify itself on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Medicare.

J. Additional Requirements for Delegated Providers

Providers that are delegated for claims and utilization management activities are the “business associates” of Molina Healthcare. Under HIPAA, Molina Healthcare 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.

VIII. Utilization Management

Molina Medicare maintains a Utilization Management (UM) Department to work with members and providers in administering the Molina Medicare Utilization Management Program. You can contact the Molina Medicare UM Department for your state by phone at **888-483-0760** or fax **866-472-0589**.

The address for mail requests is:

Molina Medicare
Molina Healthcare of Utah
7050 Union Park Center, Suite 200
Midvale, Utah 48047

This provider manual contains excerpts from the Molina Medicare Utilization Management Program Description (UMPD). For a complete copy of your state's Molina Medicare UMPD you can access the Molina Medicare website at www.molinamedicare.com or contact the phone number above to receive a written copy. You can always find more information about Molina Medicare Utilization Management including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer by accessing www.molinahealthcare.com or calling the UM Department at the number listed above.

Molina Medicare's Utilization Management (UM) Program is designed to provide comprehensive health care management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service.

Molina Medicare works in partnership with Members and Providers to promote a seamless delivery of health care services. Molina Medicare managed care programs balance a combination of benefit design, reimbursement structure, information analysis and feedback, consumer education, and active intervention that manages cost and improves quality.

Medical Groups/IPAs who assume responsibility for utilization management must adhere to Molina Medicare's standards of care and UM Policies. Their programs, policies and supporting documentation are reviewed by Molina Medicare at least yearly.

A. Utilization Management Goals

The goals of the Utilization Management Program at Molina Medicare are to:

- Identify medical necessity and appropriateness to ensure efficiency of the health care services provided.
- Continually monitor, evaluate and optimize the use of health care resources.
- Monitor utilization practice patterns of participating physicians, hospitals and ancillary Providers to identify over and under service utilization.
- Identify and assess the need for Care Management / Disease Management through early identification of high or low service utilization and high cost, chronic or long term diseases.
- Promote health care in accordance with local, state and national standards.

- Identify events and patterns of care in which outcomes may be improved through efficiencies in utilization management, and to implement actions that improve performance.
- Ensure timely responses to Member appeals and grievances.
- Continually seek to improve Member and Provider satisfaction with health care and with Molina Medicare utilization processes.

B. Prior Authorization

Molina Medicare requires authorization for selected medical procedures, pharmaceuticals, medical equipment and services. The list of items requiring prior authorization is subject to change and so is not published here. A copy of the most recent prior authorization requirements can be found at the Molina Medicare website or a written copy can be obtained by contacting the UM Department at the phone numbers noted in the introduction to the Utilization Management section of this provider manual.

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

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

<ul style="list-style-type: none"> • Member demographic information (Name, DOB, Id # etc.) • Provider information (Referring Physician and Referred to Specialist) • Requested service/procedure (including specific CPT/HCPCS Codes) • Member diagnosis (ICD-9 Code and description) 	<ul style="list-style-type: none"> • Clinical indications necessitating service or referral • Pertinent medical history (include. treatment, diagnostic tests, examination data) • Location where the service will be performed • Requested length of stay (for inpatient requests)
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Molina Medicare will process requests for prior authorization and notify members and providers of its determination using CMS approved timeframes and notification standards. A summary of the timeframes and notification standards is found in this Section, N.4.below.

Upon approval, the requestor will receive an authorization number. The number may be provided by phone 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. Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the Member’s health condition. The written letter is mailed at the time the denial is issued.

C. Affirmative Statement about Incentives

Molina Medicare requires that all medical decisions are coordinated and rendered by qualified Primary Care Providers and licensed staff unhindered by fiscal or administrative concerns and ensures through communications to Providers, Members and staff that Molina Medicare and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Furthermore, Molina Medicare affirms that all UM decision making is based only on appropriateness of care and service and existence of coverage for its Members, and not on the cost of the service to either Molina Medicare or the delegated group. Molina Medicare does not specifically reward providers or other individuals for issuing denials of coverage or care. Financial incentives for Molina Medicare UM decision makers do not encourage decisions that result in underutilization. All Utilization Management policies are focused on providing Members appropriate care, in the appropriate setting at the appropriate time.

D. Open Communication about Treatment

Molina Medicare prohibits contracted Providers from limiting Provider/Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. Molina Medicare 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 Medicare 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.

E. Utilization Management Functions Performed Exclusively by Molina Medicare

The following utilization management functions are conducted by Molina Medicare (or by an entity acting on behalf of Molina Medicare) and are **never delegated**:

1. Transplant Case Management

Molina Medicare does not delegate management of transplant cases to the medical group. Providers are required to notify Molina Medicare's Utilization Management Department when the need for a transplant evaluation has been identified. Contracted Providers must obtain prior authorization from Molina Medicare for transplant evaluations and surgery. Upon notification, Molina Medicare conducts medical necessity review. Molina Medicare selects the facility to be accessed for the evaluation and possible transplant.

2. Clinical Trials

Molina Medicare does not delegate to Providers the authority to determine and authorize clinical trials. Providers are required to comply with protocols, policies, and procedures for clinical trials as set forth in Molina Medicare's contracts. For information on clinical trials,

the Providers may contact Medicare directly, or refer to the Medicare Web site: www.cms.hhs.gov or by calling 1-800-MEDICARE.

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

3. Experimental and Investigational Reviews

Molina Medicare does not delegate to Providers the authority to determine and authorize experimental and investigational (E & I) reviews. Providers are required to comply with protocols, policies, and procedures for E & I as set forth in Molina Medicare's contracts. If a Provider would like to request authorization for services that are investigational in nature please call your Provider Services representative who will check Molina Medicare's policy for the specific services.

F. Delegated Utilization Management Functions

Medical Groups/IPAs with delegated utilization management functions must be prior approved by Molina Medicare and be in compliance with all current Molina Medicare policies. Molina Medicare may delegate utilization management functions to qualifying Medical Groups/IPAs depending on their ability to meet and maintain specific delegation criteria in compliance with all current Molina Medicare policies and regulatory and certification requirements.

Utilization management activities that may be delegated include:

- Inpatient admissions
- Discharge Planning
- Retrospective / Post-service Review
- Medical Case Management
- Transition of Care When Benefits End
- Organizational Determinations
- Member Notification of Provider Termination (SNF, HHC, Free Standing Restorative Centers, PT, OT, ST)
- Emergency and Post-Stabilization Services
- Manage of Out-of-Area / Out-of-Network Admissions

G. Prospective / Pre-Service Review

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

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

H. Concurrent Review

The concurrent review must promote appropriate inpatient lengths of stay while supporting quality outcomes. The concurrent review process assures the following:

- Services are timely and efficient
- Comprehensive treatment plan is established
- Member is not being discharged prematurely
- Member is transferred to appropriate in-network hospital or alternate levels of care when clinically indicated
- Effective discharge planning is implemented
- Member appropriate for outpatient case management is identified and referred
- Decisions must be guided by a standard set of nationally recognized criteria

I. Inpatient Facility Admission

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

Notifications can be submitted by phone or fax (in some states email notification may be available, contact your Molina Medicare UM Department for availability). Contact phone numbers and fax numbers are noted in the introduction to the Utilization Management section of this provider manual.

J. Discharge Planning

Discharge planning begins on admission, and is designed for early identification of medical / psychosocial issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost effective quality driven treatment interventions for post-hospital care at the earliest point in the admission. The discharge planning process must involve communication with hospitals and Providers to ensure that a patient's needs are met upon hospital discharge, and that the discharge occurs in a timely manner. Upon discharge, the Provider must include the Member demographic information plus the discharge date and disposition.

Concurrent Review Nurses work closely with the hospital discharge planners to determine the most appropriate discharge setting for the patient. The concurrent review nurses review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment, skilled nursing facility and rehabilitative services.

K. Retrospective / Post Service Review

The post service/retrospective review process of inpatient and outpatient facility and professional claims assures that medical resource utilization was appropriate and medically necessary. Standards for retrospective review decisions are based on medical necessity determinations, appropriateness of admission, length of stay, level of care, eligibility verification, initiation of appropriate follow-up for utilization, quality and risk issues, appropriateness of billing, and identification and resolution of claims related issued.

L. Medical Case Management

The Medical Case Management Program must promote the highest quality care in the most cost-effective manner. The Case Management Program must focus on the delivery of quality cost-effective, appropriate healthcare services for Members with complex and chronic care needs. Proactive processes must be implemented to identify, coordinate, and evaluate appropriate high quality services which may be delivered on an ongoing basis.

To initiate the case management process, the Member is screened for appropriateness for case management program enrollment using specified criteria. Criteria are used for opening and closing cases appropriately with notification to Member and Provider.

1. The role of the Case Manager includes:

- Coordination of quality and cost-effective services;
- Appropriate application of benefits;;
- Promotion of early, intensive interventions in the last restrictive setting;
- Provision of accurate and up-to-date information to Providers regarding assessment;
- Creation of individualized care plans, updated as the Member's healthcare needs change;
- Utilization of multidisciplinary clinical, rehabilitative and support services;
- Arrangement of appropriate resources;
- Attention to Member satisfaction;
- Attention to the handling of PHI and maintaining confidentiality;
- Provision of ongoing analysis and evaluation;
- Protection of Member rights; and
- Protection of Member responsibility and self-management.

2. Referral to Case Management may be made by any of the following entities:

- Member or Member's designated representative
- Member's Primary Care Provider
- Specialists
- Hospital Staff
- Home Health Staff
- Molina Medicare staff

M. Transition of Care

The transition of care process assists Molina Medicare Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Medicare Members whose benefits are ending and are in need of continued care.

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

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

N. Organization Determinations

An organization determination is any determination (i.e., an approval or denial) made by Molina Medicare or the delegated Medical Group/IPA with respect to the following:

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

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

Clinical criteria do not replace Medicare Coverage Determinations when making decisions regarding appropriate medical treatment for Molina Medicare Members. As a Medicare Plan(s), Molina Medicare and its delegated Medical Group/IPAs, at a minimum, cover all services and items required by Medicare.

Requests for authorization not meeting criteria must be reviewed by a designated physician or presented to the appropriate committee for discussion and a determination. Only a physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine

specialist as appropriate) may determine to delay, modify or deny services to a Member for reasons of medical necessity.

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

1. Standard Initial Organization Determinations (Pre-service)

Standard initial organization determinations must be made as soon as medically indicated, within a maximum of 14 calendar days after receipt of the request. The table under number 4 below describes the CMS required decision timeframes and notification requirements followed by Molina Medicare.

2. Expedited Initial Organization Determinations

A request for expedited determinations may be made. An organization determination is expedited if applying the standard determination timeframes could seriously jeopardize the life or health of the member or the member's ability to re-gain maximum function. Molina Medicare and any delegated Medical Group/IPA is responsible to appropriately log and respond to requests for expedited initial organization determinations.

- Expedited Initial Determinations must be made as soon as medically necessary, within 72 hours (including weekends and holidays) following receipt of the validated request.
- Delegated Medical Group/IPAs are responsible for submitting a monthly log of all Expedited Initial Determinations to Molina Medicare's Delegation Oversight Department that lists pertinent information about the expedited determination including Member demographics, data and time of receipt and resolution of the issue, nature of the problem and other information deemed necessary by either Molina Medicare or the Medical Group/IPA. The table under number 4 below describes the CMS required decision timeframes and notification requirements followed by Molina Medicare.

3. Written notification of denial

The Member must be provided with written notice of the determination, if the decision is to deny, in whole or in part, the requested service or payment. If the Member has an authorized representative, the representative must be sent a copy of the denial notice. The appropriate written notice, that has the Centers for Medicare and Medicaid Services (CMS) approval, must be issued within established regulatory and certification timelines. The adverse organization determination templates shall be written in a manner that is understandable to the Member and shall provide the following:

- The specific reason for the denial, including the precise criteria used to make the decision that takes into account the Member's presenting medical condition, disabilities and language requirements, if any.
- Information regarding the Member's right to a standard or expedited reconsideration and the right to appoint a representative to file and appeal on the Member's behalf.

- Include a description of both the standard and expedited reconsideration process, timeframes and conditions for obtaining an expedited reconsideration, and the other elements of the appeals process
- Payment denials shall include a description of the standard reconsideration process, timeframes and other elements of the appeal process.
- A statement disclosing the Member’s right to submit additional evidence in writing or in person.

Failure to provide the Member with timely notice of an organization determination constitutes an adverse organization determination which may be appealed.

4. Utilization Management Timeliness Standards Centers for Medicare & Medicaid Services (CMS)

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	May extend up to 14 calendar days. Note: Extension allowed only if Member requests or the Provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the Member (for example, the receipt of additional medical evidence from non-contracted Providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted Providers.	Use the MA-Extension: Standard & Expedited to notify Member and Provider of an extension. Extension Notice: Give notice in writing within 14 calendar days of receipt of request. The extension notice must include: The reasons for the delay The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. Note: The Health Plan must respond to an expedited grievance within 24 hours of receipt. Decision Notification After an Extension: Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.

Type of Request	Decision	Notification Timeframes
<p>Expedited Initial Organization Determination - If Expedited Criteria are not met</p>	<p>Promptly decide whether to expedite – determine if: Applying the standard timeframe could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function, or If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a Member’s request for an expedited decision.</p> <p>If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: Automatically transfer the request to the standard timeframe. The 14 day period begins with the day the request was received for an expedited determination.</p>	<p>If request is not deemed to be expedited, give the Member prompt (within 72 hours) oral notice of the denial of expedited status including the Member’s rights followed by written notice within 3 calendar days of the oral notice. Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations; Inform the Member of the right to file an expedited grievance if he/she disagrees with the organization’s decision not to expedite the determination; Inform the Member of the right to resubmit a request for an expedited determination and that if the Member gets any physician’s support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the Member, or the Member’s ability to regain maximum function, the request will be expedited automatically; and Provide instructions about the expedited grievance process and its timeframes.</p>
<p>Expedited Initial Organization Determination - If No Extension Requested or Needed</p>	<p>As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).</p>	<p>Within 72 hours after receipt of request. Approvals Oral or written notice must be given to Member and Provider within 72 hours of receipt of request.</p>

Type of Request	Decision	Notification Timeframes
(See footnote)		<p>Document date and time oral notice is given. If written notice only is given, it must be received by Member and Provider within 72 hours of receipt of request.</p> <p>Denials When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. Document date and time of oral notice. If only written notice is given, it must be received by Member and Provider within 72 hours of receipt of request. Use NDMC template for written notification of a denial decision.</p>

5. Termination of Provider Services (SNF, HH, CORF) / Issuance of Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC)

When a termination of authorized coverage of a Member’s admission to a skilled nursing facility (SNF) or coverage of home health agencies (HHA) or comprehensive outpatient rehabilitation facility (CORF) services occurs, the Member must receive a written notice two (2) calendar days or two (2) visits prior to the proposed termination of services.

Molina Medicare or the delegated Medical Group/IPA must coordinate with the SNF, HHA or CORF Provider to ensure timely delivery of the written notice, using the approved Notice of Medicare Non-Coverage (NOMNC). Delivery of the notice is not valid unless all elements are present and Member or authorized representative signs and dates the notice to document receipt.

- The NOMNC must include the Member’s name, delivery date, date that coverage of services ends and QIO information.
- The NOMNC may be delivered earlier than two (2) days before coverage ends.
- If coverage is expected to be fewer than two (2) days in duration, the NOMNC must be provided at the time of admission.
- If a non-institutional setting the span of time exceeds two (2) days, the NOMNC must be given no later than the next to the last time services are furnished.

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

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

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

O. Continuity of Care

Molina Medicare and its contracted Providers must provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination:

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

P. Emergency and Post-Stabilization Services

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

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

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

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

Molina Medicare or its delegated Medical Group/IPA is financially responsible for these services until Molina Medicare or its delegated Medical Group/IPA becomes involved with managing or directing the Member's care.

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

Q. Delegation Oversight of Providers performing UM functions

Molina Medicare provides oversight and ongoing evaluation of those Medical Groups/IPAs delegated to perform utilization management functions. The Delegation Oversight staff is responsible for systematic monitoring of each delegated Medical Group/IPA and health plan partner to ensure their continued ability to perform the delegated activities. At least annually, the Delegation Oversight staff conducts an audit of each delegated entity to ensure compliance with Molina Medicare's delegation requirements as well as adherence to all applicable regulatory and accreditation standards. A specifically designed UM audit tool is utilized for this on-site assessment and evaluation.

1. Initial Approval for Delegation

In order to receive delegation status for utilization management activities, Provider groups must demonstrate compliance with Molina Medicare's established utilization management standards. Delegation of selected functions may occur only after an initial audit of the utilization activities has been completed and there is evidence that Molina Medicare's delegation requirements are met. Findings are presented to Molina Medicare's Utilization

Management Committee for approval and then forwarded to the Delegation Oversight Committee to make the decision for granting delegation status.

A mutually agreed upon written delegation agreement describing the responsibilities of Molina Medicare and the delegated entities will be maintained and reviewed annually. The delegation agreement includes: a written description of the specific utilization delegated activities, reporting requirements, evaluation mechanisms, and remedies available to Molina Medicare if the delegated entity does not fulfill its obligations.

2. Criteria for Delegated Utilization Management

Molina Medicare requires that delegated Providers have a written Utilization Management Program in place which includes a detailed description of the utilization management program operations. The program must have documented goals and objectives, and describe the organizational structure and staffing for performing the program functions. The utilization management program must be approved by the delegated Provider's Utilization Management Committee and/or governing board annually, and documentation of the review and approval must be submitted to Molina Medicare. Nationally recognized utilization management criteria must be included in the program to ensure consistent decision making during the review process.

Compliance with Molina Medicare's Utilization Management Program requires delegated Medical Group/IPA to meet standards that include, but are not limited to the following:

- Timely, complete and accurate response to Molina Medicare's request for information regarding Utilization Management activities.
- Compliance with Molina Medicare's requirements for determining and authorizing level of care for every patient every day.
- Actively communicates daily or as requested based on the clinical condition of the Member, with Molina Medicare's UM Department to ensure that there is accurate recording of authorized level of care by the hospital. This coordination is required to ensure accurate and timely payment of claims.
- Active collaboration and coordination with Molina Medicare's UM staff performing concurrent review, case management and discharge planning.
- Compliance with all Molina Medicare's data submission and reporting requirements.
- Maintenance of accurate, timely and consistently formatted medical records as requested.
- Providers shall educate and train hospital staff and provide sufficient oversight to ensure their compliance with Molina Medicare's UM Program requirements as they relate to prior authorization, concurrent review and discharge planning for hospitalized Members.

The delegated Provider must have an established Utilization Management Committee which meets at least quarterly to review utilization issues and determine improvement plans where indicated. Molina Medicare representatives may attend the committee meeting, with advance notice. Minutes of the Utilization Management Committee must be made available to Molina Medicare upon request. Molina Medicare Delegation Oversight staff must be permitted reasonable access to the utilization management files, minutes and records of the Provider entity for the purpose of auditing utilization management activities.

Delegated Providers are required to provide evidence that internal procedures are operational and to take appropriate action in areas where problems are identified. These Providers are responsible for providing feedback to Molina Medicare regarding the conclusions, recommendations, actions and follow-up where problems have been identified.

R. Reporting of Suspected Abuse of an Adult

Molina Medicare reports suspected or potential abuse of vulnerable adults as required by state and federal law. A vulnerable adult is defined as a person who is not able to defend themselves, protect themselves, or get help for themselves when injured or emotionally abused. A person may be vulnerable because of a physical condition or illness (such as weakness in an older adult or physical disability) or a mental or emotional condition.

A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

Mandatory reporters include:

- Molina Medicare employees who have knowledge of the abuse
- law enforcement officer
- social worker; professional school personnel; individual Provider; an employee of a facility; an operator of a facility;
- an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science Provider or health care Provider.

A permissive reporter is any individual with knowledge of a potential abuse situation who is not included in the list of mandatory reporters. A permissive reporter may report to the Molina UM Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited or neglected. Permissive or voluntary reporting will occur as needed.

The following are the types of abuse which are required to be reported:

- **Physical abuse** is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints.
- **Sexual abuse** is nonconsensual sexual contact. Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing.
- **Mental mistreatment** is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; and yelling or swearing which results in mental distress.
- **Neglect** occurs when someone, either through action or inaction, deprives a vulnerable adult of care necessary to maintain physical or mental health.
- **Self-neglect** occurs when a vulnerable adult fails to provide adequately for themselves. A competent person who decides to live their life in a manner which may threaten their safety or well-being does not come under this definition.

- **Exploitation** occurs when a vulnerable adult or the resources or income of a vulnerable adult are illegally or improperly used for another person's profit or gain.
- **Abandonment** occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter, or health care.

In the event that an employee of Molina Medicare or one of its contracted Providers encounters potential or suspected abuse of a vulnerable adult, a call must be made to the appropriate state agency. Please call the Utah State Adult Protective Services at (801) 264-7669 for Salt Lake County or (800) 371-7897 for all other counties to report an incident. Please include:

- Date abuse occurred,
- Type of abuse,
- Names of persons involved if known
- Source of Information
- Names and telephone numbers of other people who can provide information about the situation
- Any safety concerns

Molina Medicare's Care Coordination Team (CCT) will work with PCPs and Medical Groups/IPA who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/ Medical Group/IPA or other clinical personnel. 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 is immune from liability resulting from the report or testimony.

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

S. Primary Care Providers

Molina Medicare provides a panel of Primary Care Providers (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 Medicare members are required to see a PCP who is part of the Molina Medicare Network. Molina Medicare members may select or change their PCP by contacting the Molina Member Services Department.

T. Specialty Providers

Molina Medicare maintains a network of specialty providers to care for its members. Referrals from a Molina PCP are required for a member to receive specialty services however no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral. Molina Medicare 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 Medicare UM

Department. Referrals to specialty care outside the network require prior authorization from Molina.

U. Molina Medicare Special Needs Plan Model of Care

In many states Molina Medicare operates Medicare Dual Eligible Special Needs Plans (SNP) for members who are eligible for both Medicare and Medicaid. This population has a higher burden of multiple chronic illnesses and sub-populations of frail/disabled members than other Medicare Managed Care Plan types. In accordance with CMS regulations Molina Medicare has a SNP Model of Care that outlines Molina's efforts to meet the needs of the SNP population. This section of the document outlines Molina Medicare's SNP Model of Care.

1. Goals and Objectives

Molina Medicare has significant experience caring for the aged, blind and disabled who qualify for benefits under Medicaid and demonstrate complex medical needs, similar to those who qualify for benefits under a dual eligible SNP. This experience and expertise enables Molina Medicare to effectively assess and assure its members' healthcare and supportive service needs both initially and on an ongoing basis. The goals and objectives of Molina Medicare's dual eligible SNP model of care ensure that its members are provided medically necessary services on a timely basis, in the most appropriate setting and by the most qualified healthcare professionals to assure optimal outcome.

The Molina Medicare model of care includes care coordination, case management and supportive services to maximize the health status of its dual eligible SNP members in a cost effective manner.

An important component of Molina Medicare's model of care is the health risk assessment that occurs for each dual eligible SNP member upon enrollment. The assessment ensures members have access to and integration of their primary care, acute care, post-acute care, and mental health and chemical dependency services, and is designed to support new member continuity and coordination of care.

Each assessment results in a score, indicative of the member's health status, and leads to referrals for care coordination, disease management or medical case management/utilization management services as appropriate. After the initial screening assessment, ongoing review for dual eligible SNP member needs are conducted using available technology and feedback loops from concurrent utilization review, nurse advice line encounters, physician referral, member service referral and direct member referral.

In consideration of the complexity of its dual eligible SNP members' medical needs, Molina Medicare places heavy emphasis on care coordination. Molina Medicare's dual eligible SNP has care coordination teams to monitor and assist members with access to care, coordination of care, adherence to prescribed regimens, program and condition-specific education, and member involvement in their care. Although the member has a single point of contact for ease in communication and accessing assistance, the multidisciplinary care coordination team consists of nurses, care coordinators, social workers and case managers with input from allied health professionals including those with expertise in home health, pharmacy, rehabilitative care, ongoing rehabilitative and long-term care needs. Decision support tools

are used to ensure that established clinical protocols are utilized in directing the member's care, education and guidance. Disease management programs that screen dual eligible SNP members for specific high-risk conditions such as asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease and diabetes, are part of the continuum of medical management programs applied by Molina Medicare. These disease management programs consider the member's quality of life and functional status and are blended with Molina Medicare's medical case management and care coordination programs.

Generally stated, the goals and objectives of Molina Medicare's dual eligible SNP model of care, applicable to all members, are as follows:

- Assure that all members are assessed upon enrollment and periodically thereafter and that an individualized care plan is developed when appropriate and followed,
- Assure that members receive medically necessary healthcare and supportive services of high quality,
- Assure that members receive the most appropriate level of care, in a timely manner, by a qualified provider and in the most beneficial setting,
- Assure that members receive education, assistance and advocacy services to help them identify their own care needs and to proactively seek out appropriate and timely treatment,
- Assure that members receive medically necessary preventive and palliative treatment to avoid costly complications and adverse health outcomes, and
- Assure that members are provided with supportive services to decrease or eliminate barriers to health care.

2. Goals and objectives specific to subpopulations: frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

Molina Medicare's dual eligible SNP model of care includes the following goals that are specific to **frail and disabled members**:

- Assure that members have access to community resources,
- Assure that members receive care in the least restrictive setting appropriate with the needs and commensurate with their wishes, and
- Assure that any identified mental health disabilities are appropriately managed through the assistance of a designated social worker.

Molina Medicare's dual eligible SNP model of care includes the following goals that are specific to **members with multiple chronic illnesses**:

- Assure that the healthcare needs of members are coordinated through a PCP who receives education and support from Molina Medicare staff as appropriate, and
- Assure that both members and their healthcare and support service providers receive educational and supportive assistance to help the members improve or maintain health status.

Molina Medicare's dual eligible SNP model of care includes the following goal specific to **members at the end of life**:

- Assure that members receive all necessary palliative and supportive services in a compassionate and dignified manner.

3. Organization of Staff - Employees, community service workers, nurse practitioners, case managers, etc. that interact with dual-eligible individuals to provide the specialized services available under the model of care.

Molina Medicare’s member advocacy and services philosophy is designed and administered to assure members receive value-added coordination of health care and services that ensures continuity and efficiency and that produces optimal outcomes. Molina Medicare staff members are organized in a manner to meet this objective, and include:

- Member Service representatives – front line interaction with members to address inquiries, direct calls to appropriate departments and assist with resolving issues.
- A Care Coordination Team comprised of the following positions and roles:
 - Authorization Technician – authorizes services within their scope of training and job parameters based upon predetermined criteria.
 - Care Managers (RN/LPN) – assess, authorize, coordinate and evaluate services in conjunction with the member, providers and other team members based on member’s needs, medical necessity and predetermined criteria.
 - Case Managers (RN/Social Worker) – assess and manage members’ medical, psychosocial, physical and spiritual needs – develop, implement, monitor and evaluate care plans in conjunction with members, their providers and other team members.
 - Pharmacy Technician – processes prior authorization and exception requests for Part D benefits.
 - Appeals and Grievance Coordinator – assists member in filing and resolving complaints related to care issues, keeping member rights at the forefront.

4. The lines of communication and accountability between the SNP and the care delivery staff.

The success of the care coordination program is dependent upon open communication and establishing relationships between the plan, the staff and the member. Additionally, it is imperative that all of the care providers and community resources involved with the member communicate with the care coordination team in order to create a coordinated care environment.

The member or member representative is at the center of the model and is included in all aspects of planning and coordination. The number of communications involving the member is determined, to some degree, by the acuity level assigned to the member following an in-depth assessment.

The Care Coordination Team is also in contact with the PCP, specialty providers, community agencies and social services resources as needed.

5. Specific steps the Molina’s Special Needs Plan takes (e.g. written protocols and training) to ensure that the staff understands how the model of care works and how to function in accordance with the model of care.

All new employees to the Care Coordination Team are oriented and trained on concepts, components and processes involved in utilization management, care/case management. New staff are assigned a preceptor during their orientation to ensure that standards, policies and procedures are understood and followed by the new employee. Inter-rater reliability exercises are conducted on a regular basis with the members of the team that issue authorizations for services. Interdisciplinary case conferences are held on a regular basis to allow for peer discussion regarding application of criteria as well as serve as an opportunity to evaluate the consistent application of benefits, care management and review criteria.

6. Specific Needs of dual-eligible beneficiaries and how Molina Medicare identifies and meets the specialized needs of dual-eligible beneficiaries.

As previously noted, all members receive an initial health risk assessment upon enrollment. Based on the results of this assessment, more in-depth assessment tools may be used to determine specific physical and mental health, chemical dependency and/or social needs. On an ongoing basis, needs may also be determined by the type and frequency of service requests.

7. Molina Medicare’s model of care specifically addresses the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

Molina Medicare dual eligible SNP members who are frail and/or disabled are identified initially through the health risk assessment administered to every member upon enrollment, as previously noted. A more in-depth assessment is conducted for any member with a baseline need related to physical condition, mental health or chemical dependency. Subsequent to enrollment, identification can also be made by type and number of service requests, information offered by a provider or a referral from another team member with in the plan or from a risk alert received from the state Medicaid agency. Based on the member’s needs, an individualized care plan may be generated and assistance with coordinating their care through appropriate providers is facilitated.

Molina Medicare dual eligible SNP members who have multiple chronic illnesses are identified initially through the health risk assessment administered to every member upon enrollment, as previously noted. A more in-depth assessment is conducted for any member with a baseline need related to physical condition, mental health or chemical dependency. Subsequent to enrollment, identification can also be made by type and number of service requests, information offered by a provider or a referral from another team member with in the plan or from a risk alert received from the state Medicaid agency. Based on the member’s needs, an individualized care plan may be generated and assistance with coordinating their care through appropriate providers is facilitated. These members will be enrolled in one or more disease management programs as applicable.

Molina Medicare dual eligible SNP members who are at the end of life may, if their condition is known, be identified through the health risk assessment administered to every member upon enrollment, as previously noted above. Subsequent to enrollment, identification can also be made by type and number of service requests, information offered by a provider or a referral from another team member within the plan or from a risk alert received from the state Medicaid agency. Based on the member's needs, an individualized care plan may be generated and assistance with coordinating their care through appropriate providers is facilitated whether that is hospice, home health care or pain management. If and when the member chooses to enroll in a hospice program, their care related to the terminal illness is coordinated by fee-for-service Medicare. Care unrelated to the terminal illness continues to be managed and coordinated by Molina Medicare.

8. Extra Benefits and Services Molina Medicare provides to meet the needs of dual-eligible beneficiaries appropriate to their condition and need:

- Health and wellness education to allow members to be proactive in their healthcare needs,
- Assistance from a member navigator and social worker in accessing community resources,
- Social worker expertise for mental health/chemical dependency issues,
- Preventative care and screening tests to assist with early recognition of healthcare issues and/or to prevent costly complications,
- Disease management programs for diabetes, asthma, heart disease and COPD, as well as maternity if necessary,
- Nurse Advice Line – 24-hour unlimited telephone access to a registered nurse who can answer medical questions, and
- Medication therapy management to decrease poly pharmacy and drug interactions

9. Extra Benefits and Services Molina Medicare provides to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life appropriate to their condition and need:

- Health and wellness education to allow members to be proactive in their healthcare needs.
- Assistance from a member navigator and social worker in accessing community resources,
- Social worker expertise for mental health/chemical dependency issues,
- Preventative care and screening tests to assist with early recognition of healthcare issues and/or to prevent costly complications,
- PCP to provide oversight and coordination of medical care
- Disease management programs for diabetes, asthma, heart disease and COPD, as well as maternity if necessary,
- Nurse Advice Line – 24-hour unlimited telephone access to a registered nurse who can answer medical questions,
- Medication therapy management to decrease poly pharmacy and drug interactions,

- Onsite visits by team members (care/case managers, social worker, member navigator) to better determine their needs and compliance with their treatment plan, and
- Care/Case Management to coordinate care in an appropriate, cost effective manner.

Molina Medicare dual eligible SNP members who have multiple chronic illnesses receive the following extra benefits and services appropriate to their condition and need:

- Health and wellness education to allow members to be proactive in their healthcare needs.
- Assistance from a member navigator and social worker in accessing community resources,
- Social worker expertise for mental health/chemical dependency issues,
- Preventative care and screening tests to assist with early recognition of healthcare issues and/or to prevent costly complications,
- PCP to provide oversight and coordination of medical care
- Disease management programs for diabetes, asthma, heart disease and COPD, as well as maternity if necessary,
- Nurse Advice Line – 24-hour unlimited telephone access to a registered nurse who can answer medical questions,
- Medication therapy management to decrease poly pharmacy and drug interactions,
- Onsite visits by team members (care/case managers, social worker, member navigator) to better determine their needs and compliance with their treatment plan, and
- Care/Case Management to coordinate care in an appropriate, cost effective manner.

Molina Medicare dual eligible SNP members who are at the end of life receive the following extra benefits and services appropriate to their condition and need:

- Health and wellness education to allow members to be proactive in their healthcare needs.
- Assistance from a social worker in accessing community resources,
- Social worker expertise for counseling issues with the member and/or family,
- Nurse Advice Line – 24-hour unlimited telephone access to a registered nurse who can answer medical questions,
- Medication therapy management to decrease poly pharmacy and drug interactions,
- Onsite visits by team members (care/case managers, social worker) to better determine their needs and compliance with their treatment plan,
- Care/Case Management to coordinate care in an appropriate, cost effective manner, and
- Palliative care to allow the member to be as comfortable as possible.

10. Specific processes and outcome measures Molina Medicare uses to evaluate performance of the model of care for dual-eligible beneficiaries.

Members will be asked to complete an Annual Access survey to determine issues related to accessing care. Additionally, Molina Medicare will review all quality reports such as Health Risk Appraisal timeliness reports, grievance and appeal reports, quality of care issues, under

and over-utilization reports, results of inter-rater reliability testing, annual review of Medicare CAHPS survey with attention to utilization management results, disease management program reports, Medication Therapy Management Program reports as well as member satisfaction surveys.

11. Specific processes and outcome measures Molina Medicare uses to evaluate performance of the model of care for frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

If they are able to do so, members who are frail/disabled, have multiple chronic illnesses or are near end of life, are asked to complete an Annual Access survey to determine issues related to accessing care. Additionally, Molina Medicare reviews all quality reports such as Health Risk Appraisal timeliness reports, grievance and appeal reports, quality of care issues, under and over-utilization reports, results of inter-rater reliability testing, annual review of Medicare CAHPS survey with attention to utilization management results, disease management program reports, Medication Therapy Management Program reports as well as member satisfaction surveys.

12. The Molina Medicare SNP provider and pharmacy networks are not different than the networks for other Molina Medicare plans in the same service area.

13. Pertinent clinical expertise used in the provider network to meet the special needs of the dual-eligible population.

Molina Medicare has significant experience caring for members with complex medical and social needs. We also contract with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members. Molina Medicare maintains a contracted full service network of providers who must comply with specific policies and procedures for initial credentialing and re-credentialing and who are compliant with NCQA and CMS credentialing standards. Network participation is dependent upon all providers meeting the requirements on an on-going basis.

The paneled network covers all proposed service areas. PCP's and specialists have been contracted to provide all covered services. All other ancillary service providers, such as home health, DME and outpatient services are also available. Our panel consists of board certified Geriatricians as well as providers certified in Physical and Medical Rehabilitation to meet the needs of all of our membership.

14. Pertinent clinical expertise used to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

Molina Medicare has significant experience caring for members with complex medical and social needs. We also contract with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members. Molina Medicare maintains a contracted full service network of providers who must comply with specific policies and procedures for initial credentialing and re-credentialing and who are

compliant with NCQA and CMS credentialing standards. Network participation is dependent upon all providers meeting the requirements on an on-going basis. The paneled network covers all proposed service areas. PCP's and specialists have been contracted to provide all covered services. All other ancillary service providers, such as home health, DME and outpatient services are also available. Our panel consists of board certified Geriatricians as well as providers certified in Physical and Medical Rehabilitation to meet the needs of all of our membership,

15. If the existing network does not include sufficient specialists to fully meet the special needs of the target population.

In the event that a medically necessary, covered service is not available or inadequate to meet a member's needs, the PCP may request an authorization for care outside of the network. Out-of-area urgent and emergent services will be covered within the United States.

IX. Members Rights and Responsibilities

Molina Medicare Members have certain rights to help protect them. In this section, Member rights and responsibilities are outlined based on Molina Medicare of Utah's Evidence of Coverage document that each Member receives.

A. Members have a right to:

- 1. Be treated with dignity, respect and fairness.** Molina does not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If Member's need help with communication, such as help from a language interpreter, they are asked to call Member Services at **888-665-1328**. Member Services can also help Member's file a complaint about access (such as wheel chair access). Members may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or the local Office for Civil Rights.
- 2. Privacy of medical records and personal health information.** There are federal and state laws that protect the privacy of medical records and personal health information. Molina Medicare protects our Member's personal health information under these laws. Any personal information that is provided when a Member enrolls is protected and that unauthorized people do not see or change records.

Generally, we must get written permission from Members (or from someone given legal power by the Member) before we can give health information to anyone who is not providing care or paying for care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. Molina will release information, including prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

- 3. See network providers, get covered services, and get prescriptions filled within a reasonable period of time.** Members have the right to choose a network provider (and Molina will tell Members which providers are accepting new patients). Members have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to timely access to providers and to see specialists when care from a specialist is needed. Timely access means that Members can get appointments and services within a reasonable amount of time. Please refer to Section VI – Quality Improvement – Part B – Access to Care.
- 4. Members have the right to get full information from providers when they go for medical care and the right to participate fully in decisions about their health care.** Providers must explain things in a way that patients/Members can understand. Their rights include knowing about all of the treatment options that are recommended for their condition, no matter what they cost or whether they are covered by our Plan. This includes the right to know about the different Medication Therapy Management Programs we offer and in which they may participate. They have the right to be told about any risks involved in their care.

They must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

They have the right to receive a detailed explanation from Molina Medicare if they believe that a provider has denied care that they believe they were entitled to receive or care they believe they should continue to receive. In these cases, they must request an initial decision called an organization determination or a coverage determination. Organization determinations and coverage determinations are discussed in Sections XIV and XV.

They have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if their provider advises them not to leave. This includes the right to stop taking their medication. If they refuse treatment, they accept responsibility for what happens as a result of their refusing treatment.

5. Use advance directives (such as a living will or a power of attorney).

Members have the right to ask someone such as a family member or friend to help them with decisions about their health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If they want to, they can use a special form to give someone the legal authority to make decisions if they ever become unable to make decisions for themselves. They also have the right to give their providers written instructions about how they want them to handle their medical care if they become unable to make decisions. The legal documents that they can use to give their directions in advance in these situations are called advance directives. There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

If they want to have an advance directive, they can get a form from their lawyer, from a social worker, or from some office supply stores. They can sometimes get advance directive forms from organizations that give people information about Medicare. Regardless of where they get this form, keep in mind that it is a legal document. They should consider having a lawyer help they prepare it. It is important for them to sign this form and keep a copy at home. They should give a copy of the form to their provider and to the person they name on the form as the one to make decisions for they if they can not. They may want to give copies to close friends or family members as well.

If they know ahead of time that they are going to be hospitalized, and they have signed an advance directive, they are asked to take a copy with to the hospital. If they have not signed an advance directive form, the hospital will provide forms available and will ask if they want to sign one.

It is their choice whether they want to fill out an advance directive (including whether they want to sign one if they are in the hospital). According to law, no one can deny them care or discriminate against them based on whether or not they have signed an advance directive. If they have signed an advance directive, and they believe that a provider or hospital has not followed the instructions in it, they may file a complaint with:

6. Get information about our Molina Medicare Health Plans.

Members have the right to get information from us about our Plan. This includes information about our financial condition, and how our Plan compares to other health plans. To get any of this information, call Member Services at **888-665-1328**.

7. Get information in other formats.

Members have the right to get their questions answered. Molina Medicare must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If they have difficulty obtaining information from our plan based on language or a disability, Members may also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

8. Get information about Molina network pharmacies and providers.

They have the right to get information from Molina about our network pharmacies, providers and their qualifications and how we pay our providers. To get this information, they may call Member Services at **866-440-0012**.]

9. Get information about their prescription drugs, Part C medical care or services, and costs.

Members have the right to an explanation from Molina about any prescription drugs or Part C medical care or service not covered by our Plan. We must tell them in writing why we will not pay for or approve a prescription drug or Part C medical care or service, and how they can file an appeal to ask us to change this decision. See Sections XIV and XV for more information about filing an appeal. They also have the right to this explanation even if they obtain the prescription drug, or Part C medical care or service from a pharmacy and/or provider not affiliated with our organization. They also have the right to receive an explanation from us about any utilization-management requirements, such as step therapy or prior authorization, which may apply to their plan. Please review our formulary at www.molinamedicare.com.

10. Make complaints. Members have the right to make a complaint if they have concerns or problems related to their coverage or care. See Sections XIV and XV for more information about complaints. If they make a complaint, Molina Medicare must treat them fairly (i.e., not retaliate against them) because they made a complaint. They have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services at **866-440-0012**.

B. Members have a responsibility to:

- 1. Get familiar with their coverage** and the rules they must follow to get care. As a member, they are asked to learn about their coverage, what they have to pay, and the rules they need to follow.
- 2. Inform Molina if they have additional health insurance or drug coverage and to use all of their insurance coverage.** If they have additional health insurance coverage or

prescription drug coverage besides our Plan, it is important that they use their other coverage in combination with their coverage as a member of our Plan to pay their health care or prescription drug expenses. This is called “coordination of benefits” because it involves coordinating all of the health or drug benefits that are available to them.

3. **Notify providers when seeking care** (unless it is an emergency) that they are enrolled in a Molina Medicare plan and they must present their plan membership card to the provider.
4. **Give their provider and other providers the information they need to care for them**, and follow the treatment plans and instructions that they and their providers agree upon.
5. **Act in a way that supports the care given** to other patients and helps the smooth running of their provider’s office, hospitals, and other offices.
6. **Pay their coinsurance or copayment** for their covered services. They must pay for services that are not covered.
7. **Notify Molina if they move.** If they move within our service area, we need to keep their membership record up-to-date. If they move outside of our plan service area, they cannot remain a member of our plan, but we can let them know if we have a plan in that area.
8. **Let Molina Medicare** know if they have any questions, concerns, problems, or suggestions.

X. Provider Responsibilities

A. Provision of Covered Services

Providers will render covered services to Members within the scope of the Provider's business and practice, in accordance with the Provider's contract, Molina Medicare's policies and procedures, the terms and conditions of the Molina Medicare product which covers the Member and the requirements of any applicable government-sponsored program.

B. Standard of Care

Providers will render covered services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct and any controlling governmental licensing requirements.

C. Facilities, Equipment and Personnel

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

D. Referrals

When a Provider determines that it is medically necessary to consult or obtain services from other specialty health professionals, the Provider should make a referral in accordance with Molina Medicare's Provider manual unless the situation is one involving the delivery of emergency services. Providers should coordinate the provision of specialty care in order to ensure continuity of care.

E. Contracted Providers

Except in the case of emergency services or after receiving prior authorizing of Molina Medicare, Provider should use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and Providers, which have contracted with Molina Medicare.

F. Member Eligibility Verification

Providers should verify eligibility of Members prior to rendering services as Medicare Advantage and Prescription Drug Plan (Options) Members may switch health plans during the open enrollment period from November 15 to December 31 and also during the switch enrollment period from January 1 to March 31. Special Needs Plan (Options Plus) Members may switch health plans every month if desired.

G. Admissions

Providers are required to comply with Molina Medicare's facility admission and prior authorization procedures.

H. Prescriptions

Providers are required to abide by Molina Medicare drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name

pharmaceuticals. Providers should obtain prior authorization from the Molina Medicare Pharmacy Department if the Provider believes it is necessary to prescribe a non-formulary drug or a brand name drug when generics are available.

The only exceptions are prescriptions and pharmaceuticals ordered for inpatient facility services. Molina Medicare's contracted pharmacies/pharmacists may substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

I. Subcontract Arrangements

Any subcontract arrangement entered into by a Provider for the delivery of covered services to Members must be in writing and will bind the Provider's subcontractors to the terms and conditions of the Provider's contract including, but not limited to, terms relating to licensure, insurance, and billing of Members for covered services.

J. Availability of Services

Providers must make necessary and appropriate arrangements to assure the availability of covered services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member visits after hours. Providers are to meet the applicable standards for timely access to care and services as outlined in this manual in Section VI, taking into account the urgency of the need for the services.

K. Treatment Alternatives and Communication with Members

Molina Medicare endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina Medicare 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.

L. Nondiscrimination

Providers will not differentiate or discriminate in providing covered services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care. Providers are to render covered services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payer.

M. Maintaining Member Medical Record

Providers are to maintain a medical record for each Member to whom health care services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record should contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Molina Medicare's policies and procedures. Providers are to retain all such records for at least ten years.

N. Confidentiality of Member Health Information

Providers are expected to comply with all applicable state and federal laws. Refer to Section VII for HIPAA requirements and information.

O. HIPAA Transactions

Providers are expected to comply with all HIPAA TCI (transactions, code sets, and identifiers) regulations. Refer to Section VII for HIPAA requirements and information.

P. National Provider Identifier (“NPI”)

Providers are expected to comply with all HIPAA NPI regulations. Refer to Section VII HIPAA requirements and information.

Q. Delivery of Patient Care Information

Providers are to promptly deliver to Molina Medicare, upon request and/or as may be required by state or federal law, Molina Medicare’s policies and procedures, applicable government sponsored health programs, Molina Medicare’s contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by the Provider, including but not limited to, any and all information requested by Molina Medicare in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Molina Medicare’s Quality Improvement Program, or claims payment. Providers will further provide direct access to patient care information as requested by Molina Medicare and/or as required to any governmental agency or any appropriate state and federal authority having jurisdiction. Molina Medicare will have the right to withhold compensation from the Provider in the event that the Provider fails or refuses to promptly provide any such information to Molina Medicare.

CMS has specific guidelines for the retention and disposal of Medicare records. Please refer to <http://www.cms.hhs.gov/manuals/downloads/ge101c07.pdf> for guidance.

R. Member Access to Health Information

Providers are expected to comply with all applicable state and federal laws. Refer to Section VII for HIPAA requirements and information.

S. Participation in Grievance Program

Providers are expected to participate in Molina Medicare’s Grievance Program and cooperate with Molina Medicare 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 grievance. If a Member appeals, the Provider would participate by providing medical records or statement if needed. Please refer to Section XIV regarding Member’s Appeals and Grievances.

T. Participation in Quality Improvement Program

Providers are expected to participate in Molina Medicare’s Quality Improvement Program and cooperate with Molina Medicare in conducting peer review and audits of care rendered by Providers.

U. Participation in Utilization Review and Management Program

Providers are required to participate in and comply with Molina Medicare's utilization review and management programs, including all policies and procedures regarding prior authorizations, and cooperate with Molina Medicare in audits to identify, confirm, and/or assess utilization levels of covered services.

V. Participation in Credentialing

Provider will participate in Molina Medicare's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina Medicare. The Provider is to immediately notify Molina Medicare of any change in the information submitted or relied upon by the Provider to achieve credentialed status. If the Provider's credentialed status is revoked, suspended or limited by Molina Medicare, Molina Medicare may, at its discretion, terminate the contract and/or reassign Members to another Provider.

Delegation of Credentialing: If the Provider is a Medical Group or IPA, the Provider will accept delegation of credentialing responsibilities at Molina Medicare's request and shall cooperate with Molina Medicare in establishing and maintaining appropriate credentialing mechanisms within the Provider's organization. If delegation of credentialing responsibilities to a Medical Group or IPA is revoked, Molina Medicare will reduce any otherwise applicable payments owing to Medical Group or IPA.

W. Provider Manual

Providers will comply and render covered services in accordance with the contents, instructions and procedures as outlined in this Manual, which may be amended from time to time at Molina Medicare's sole discretion.

X. Health Education/Training

Providers are to participate in and cooperate with Molina Medicare Provider education and training efforts as well as Member education and efforts. Providers are also to comply with all Molina Medicare's health education, cultural and linguistic standards, policies, and procedures.

Y. Promotional Activities

At the request of Molina Medicare, the Provider may display Molina Medicare promotional materials in its offices and facilities as practical, and cooperate with and participate in all reasonable Molina Medicare marketing efforts.

Providers shall not use Molina Medicare's name in any advertising or promotional materials without the prior written permission of Molina Medicare. In the creation of marketing materials, providers must comply with the CMS Marketing Guidelines outlined on the CMS web link below (please specifically note page 122, which begins the section entitled "Specific Guidance about Provider Promotional Activities.")

<https://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FinalMarketingGuidelines.pdf> .

XI. Claims

When billing for services rendered to Molina Medicare members, providers must use bill with the most current Medicare approved coding (ICD-9, CPT, HCPCS, etc.) available. Claims must be submitted using the proper claim form/format, e.g., for paper claim a CMS1500 or UB04 and for an electronically submitted claim – in approved ANSI/HIPAA format. It is recommended that claims be submitted as if they are being billed to Medicare fee-for-service. The following information must be included on every claim:

A. Data Elements Required

- Member's name
- Member's date of birth
- Member's Molina Medicare ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid ICD-9 diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Total billed charges for service provided
- Place and type of service code
- Days or units as applicable
- Provider tax identification
- National Provider Identifier (NPI)
- Rendering Provider as applicable
- Provider name and billing address
- Place of service
- Present on admission (POA) indicators on diagnoses for inpatient discharges
- Disclosure of any other health benefit plans and if patient's condition is related to employment, auto accident or other accident
- E-signature

Molina Medicare will only process legible claims. Handwritten claims are not acceptable and will be rejected. Claims missing detail will also be denied for incomplete data. If additional information/documentation is required to finalize a claim, Molina Medicare must receive the requested information/documentation no later than 15 calendar days from the original request date. Incomplete, inaccurate, or untimely re-submissions may result in denial of the claim.

Please submit paper claims to Molina Medicare's office at the following address:

Molina Medicare Options / Option Plus Claims
PO Box 22801
Long Beach, CA 90801

To overnight claims (physical address):

Molina of New Mexico, Inc.
One Golden Shore
Long Beach, CA 90802

B. Claims Submission Questions

Molina Medicare is concerned that all provider questions and concerns about claims are answered timely. Please refer to contact information above and in Section III.

C. Electronic Claim Submissions

Molina Medicare uses numerous clearing houses for electronic submissions of CMS1500s and facility/institutional claims. You can contact your local Provider Service Representative for the lists of clearing houses. Please use Molina Medicare's Payor ID number – 38336 when submitting claims electronically.

Molina Medicare encourages providers to track all electronic submissions using the acknowledgement reports received from the provider's current clearinghouse. These reports assure claims are received for processing in a timely manner. Additionally, WebMD clearinghouse issues an acknowledgement report to the submitting Provider within five to seven business days of claim transmission. Any problems experienced with claims transmission should be addressed to the Provider's current clearinghouse representative.

D. Timely Claim Filing

Claims for covered services rendered to Molina Medicare members must be received no later than the limitation stated in the provider contract.

E. Timely Claim Processing

A clean claim is a claim that has no defect, impropriety, lack of any required substantiating documentation as outlined in Part A above, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. The receipt date of a claim is the date Molina Medicare receives either written or electronic notice of the claim. All hard copy claims received Molina Medicare will be clearly stamped with date of receipt. Claim payment will be made to contracted providers in accordance with the timeliness provisions set forth in the Provider's contract.

F. Billing the Member

Providers contracted with Molina Medicare cannot bill the member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization as outlined in the Provider's contract.

G. Claim Adjustments

Providers seeking an adjustment of a claim previously adjudicated must request such action within 180 days of Molina Medicare's original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as an adjustment and must include the following:

- Payment adjustment requests must be fully explained.
- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the referral/authorization form (if applicable) must accompany the adjustment request.
- Requests for claim corrections/adjustments should be mailed to the address referenced at the end of this section.

- Providers requesting an adjustment, correction or reprocessing of a claim previously adjudicated by a fully delegated Medical Group/IPA must submit their request to the IPA/medical group responsible for payment of the original claim.
- Corrected claim submissions are not adjustments and should be directed through the original submission process marked as a corrected claim or it will result in the claim being denied.

H. Overpayments and Refund Requests

In the event Molina Medicare finds an overpayment on a claim or must recoup money, the provider will be mailed a letter requesting a refund of the overpayment. The provider has 60 calendar days to refund Molina Medicare. If the refund is not received within that time, the amount overpaid will be deducted from the provider's next claim payment.

All questions pertaining to refund request letters are to be directed to the Claims Customer Service Department at **888-665-1328**.

I. Third Party Liability (TPL)/Coordination of Benefits (COB)

For members enrolled in a Molina Medicare plan, Molina Medicare and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these members. Molina Medicare will pay claims for covered services; however if TPL/COB is determined post payment, Molina Medicare will attempt to recover any overpayments.

J. Medicaid coverage for Molina Medicare Members

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

Provider must submit secondary claims to Medicaid for members who may have Medicaid benefits. For those members who are enrolled with Molina's Medicare and Medicaid programs, Molina will automatically process the secondary claim. Providers are subject to all Medicare and Medicaid regulations with regard to cost-sharing protections for members.

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

K. Provider Denied Claims Review

The Provider Denied Claims Review process which differs from Member Appeals, offers recourse for Providers who are dissatisfied with a denial or decision. Molina Medicare will consider requests for Denied Claims Review that are submitted by either the Provider directly or by parties acting on behalf of the Provider (such as attorneys and collection agencies). Denied Claim Review requests must be submitted to Molina Medicare within 180 days of the initial denial.

The party requesting a Denied Claims Review must submit a letter to Molina Medicare clearly identified as "Denied Claims Review request." The written correspondence must refer to the claim number or authorization number.

Denied Claim Review requests must include all pertinent information such as

- the original claim
- prior authorization letter
- denial letter
- supporting medical records, and
- any new information pertinent to the Denied Claims Review request.

Request for Denied Claims Review submitted without this documentation may be delayed. Denied Claim Review requests submitted more than 180 days from the original decision may be denied. Request for Denied Claims Review should be mailed to the address specified in part A above.

The Provider will be notified of Molina Medicare decision in writing within 45 days of receipt of the Denied Claims Review request. Providers may **not** “bill” the Member when a denial for covered services is upheld per review. An adjustment request, which differs from “Denied Claims Review” request, must be submitted within 180 days of the original RA from Molina Medicare in order to be considered. Providers may request a claims adjustment when the claim was incorrectly denied as a duplicate or other claims examiner or data-entry error.

If the Provider has a direct contract with the delegated Medical Group/IPA, the Provider must make an initial review request or a claim adjustment request through that group..

L. Claims Review and Audit

Providers acknowledge Molina Medicare’s right to review Provider’s claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to:

- current UB manual and editor
- Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding,
- CMS billing rules
- CMS bundling/unbundling rules
- National Correct Coding Initiatives (NCCI) Edits
- CMS multiple procedure billing rules
- FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices.

Providers acknowledge Molina Medicare’s right to conduct such review and audit on a line-by-line basis or on such other basis as Molina Medicare deems appropriate and Molina Medicare’s right to exclude inappropriate line items to adjust payment and reimbursement Provider at the revised allowable level.

Providers acknowledge Molina Medicare’s right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. The Provider shall cooperate with Molina Medicare’s audits of claims and payments by providing access to:

- requested claims information
- all supporting medical records
- Provider’s charging policies; and
- other related data.

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

M. Claims Editing Process

Molina Medicare has a claims pre-payment auditing process that identifies frequent billing errors such as:

- bundling and unbundling coding
- duplicate claims
- services included in global care
- incorrect coding of services rendered.

Coding edits are generally based on Current Procedural Terminology (CPT), Health Resources and Services Administration (HRSA) and National Correct Coding Initiatives (NCCI) guidelines. If you disagree with an edit, please follow the Denied Claim Review Request guideline located in Section K (above).

N. Oversight and Monitoring of Delegated Medical Groups – Claims and Financial Reporting

Molina Medicare routinely monitors its network of delegated Medical Groups/IPAs for compliance with various standards. These requirements include, but are not limited to:

1. Claims Timeliness Reporting/Audits

Molina Medicare requires IPA/Medical Groups to submit monthly claims processing reports. These reports are due to Molina Medicare by the 15th of each month for all claims processed in the previous month.

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

Molina Medicare requires the Medical Groups/IPAs to achieve passing claims audit scores. Claims audits are conducted annually. More frequent audits are conducted when the Medical Group/IPA does not achieve the timely processing requirements referenced above.

2. Encounter Data Reporting

Molina Medicare will accept encounter data via hard copy (CMS1500 or UB04) or electronically (in specified formats). Electronic encounter data is due to Molina Medicare by the 5th day of the second month following the encounter (i.e. by August 5th for encounters occurring in June).

Hard copy encounter data is due to Molina Medicare within ninety (90) days from the end of the month following the encounter (e.g. by October 31st for all encounters occurring in July).

XII. Molina Medicare’s Anti-Fraud Program

Health care fraud is committed when someone intentionally submits or causes someone else to submit, false or misleading information for use in determining the amount of health care benefits payable. That is a crime. Any person convicted of health care fraud faces imprisonment and substantial fines. Health care fraud can be committed by dishonest health care Providers or by plan Members themselves.

A. Health Care Fraud Affects Everyone

Fraud raises the cost of health care benefits for everybody. It is estimated that losses due to fraud adds three to ten percent to the annual cost of health care in the United States. Fraud increases the cost of providing benefits and therefore the overall cost of doing business which translates into a reduction in benefits. Fraud can also impact the quality of care that a Member receives. When dishonest Providers put greed ahead of care, proper diagnosis and treatment may be ignored and patients may be put at risk solely to generate higher dollar claims.

B. What Molina Medicare is doing about Health Care Fraud

Molina Medicare takes a proactive approach to detecting and investigating potential health care fraud and abuse. Molina Medicare has an Anti-Fraud Program to detect, prevent, investigate and report fraud activity. Molina Medicare works with state and federal agencies to prevent, uncover; and stop fraud. State and federal laws require Molina Medicare to report fraud cases. Molina Medicare’s aggressive approach to the investigation of potential health care fraud cases is reflected in the Molina Medicare’s mission statement.

The mission of Molina Medicare is to implement an anti-fraud program to prevent, investigate and report suspected health care fraud in order to reduce health care costs and to promote quality health care. Molina Medicare strives to protect all health care dollars that otherwise might be lost or wasted. Molina Medicare works with Members and Providers to address issues and concerns about fraud and abuse.

C. Common examples of Health Care Provider Fraud

- Billing for services not actually performed;
- Falsifying a patient’s diagnosis to justify tests, surgeries or other procedures that are not medically necessary;
- Misrepresenting procedures performed to obtain payment for non-covered services, such as cosmetic surgery;
- “Upcoding” – billing for a more costly service than the one actually performed.
- “Unbundling” – billing each stage of a procedure as if it were a separate treatment;
- Accepting kickbacks for Member referrals;
- Billing under another Provider’s name;
- Altered claims

D. Common examples of Health Care Member Fraud

- Filing claims for services or medication not received;
- Forging or altering bills or receipts;
- Using someone else’s coverage card;

- Pretending to be someone else;
- Adding someone who is not eligible to coverage or lending an ID card to family Members or friends.

E. How to report Health Care Fraud

You may report suspected fraudulent activities by writing or telephoning the following:

MHC Compliance Department
1 Golden Shore
Long Beach, CA 90802
Attn: Director of Compliance
Voicemail (866) 449-6850
Fax (562) 499- 6150
E-mail: MHC-Compliance@Molinahealthcare.com

Be sure to give as much information as possible. All information will be kept confidential as allowed by law.

XIII. Credentialing and Recredentialing

The purpose of the Credentialing Program is to strive to assure that the Molina Medicare network consists of quality providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community.

The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

The Credentialing Program has been developed in accordance with state and federal requirements and standards of the National Committee for Quality Assurance (NCQA). In accordance with those standards, Molina Medicare Members will not be referred and/or assigned to you until the credentialing process has been completed.

A. Initial Credentialing Process

At the time of initial credentialing, the applicant must complete a credentialing application and any applicable attachments to the application. The application must be completed in its entirety, including a current and signed attestation signed by the applicant within 180 calendar days of the credentialing decision. A signature stamp is not acceptable on the attestation. The attestation must include:

- Reason for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage and
- The correctness and completeness of the application

The completed application will be processed upon submission and the credentials of the applicant will be primary source verified. If the application has not been signed or if information provided on the application is incomplete, the provider will be notified in writing and the missing information will be requested. If the provider does not provide the information in the time period requested, he/she will be deemed to have withdrawn his/her application for participation.

If the signature attestation will be older than 180 calendar days at the time of the credentialing decision, the provider is required to update the attestation. Molina will send a copy of the completed application with a new attestation form when requesting the provider update the attestation.

At a minimum, the Credentialing Department will verify the following information during the credentialing process:

- Current, unrestricted license to practice
- Current, valid Drug Enforcement Agency (DEA) certificate
- Education and training
- Work history
- Board certification
- Clinical admitting hospital privileges in good standing
- Current, adequate malpractice liability coverage
- Professional liability claims history
- Appropriate 24-hour coverage

The Credentialing Department will also:

- Identify any disciplinary actions and/or sanctions
- Query the National Provider Data Bank (NPDB)
- Query the Healthcare Integrity and Protection Data Bank (HIPDB)
- Query the U.S. Department of Health & Human Services Office of Inspector General List of Excluded Individuals/Entities
- Verify the provider has not opted out of participation with Medicare

B. Burden of Proof

The provider applying for participation in the Molina network shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability and ability to perform as a provider without limitation, including physical and mental health status as allowed by law, and the burden of resolving any doubts about these or any other qualifications to participate in the Molina Medicare network.

C. Site Review

A review of office sites at which you see Molina Healthcare Members may be required. This review will be scheduled as soon as the Credentialing Department receives your application. A passing score is required to complete the application process. Your cooperation in working with the site review staff and implementing any corrective action plans will expedite a credentialing decision.

D. Credentialing Committee

All Molina Medicare providers must be credentialed and approved by the Credentialing Committee prior to their contract becoming effective. Molina Healthcare maintains a Credentialing Committee made up of your peers. Once a credentials file contains all the necessary information (verifications, medical record and site review findings), it will be submitted for approval to the Credentialing Committee. If the Credentialing Committee determines further information is necessary to evaluate a provider's application, the Credentialing Department will request such information on behalf of the Credentialing Committee. The Credentialing Committee may, in its sole discretion, request that a provider appear for an interview.

The Governing Board of Molina Healthcare has delegated the authority to approve and to deny applicants to the Credentialing Committee. The Credentialing Committee is required to meet no less than quarterly, but generally meets on a monthly basis, to facilitate timely processing of applicant files.

E. Non-Discrimination

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g. abortions) or patients (e.g. Medicaid) in which the provider specializes. This does not preclude Molina from including in its network providers who meet certain demographic or specialty needs; for example, to meet cultural needs of members. Molina maintains a heterogeneous credentialing committee membership and requires the committee members to sign an affirmative statement at every meeting to make decisions in a nondiscriminatory manner.

F. Recredentialing

Once a Provider or facility is approved for participation in Molina Healthcare's network, recredentialing will be performed at least every three years. You will be required to submit a recredentialing application approximately six months before your credentialing period is to expire. Failure to return the recredentialing application timely will result in administrative termination from the Molina Healthcare network as a non-compliant Provider. Information that is reviewed as part of the recredentialing process includes:

Should your license, DEA, or liability insurance coverage expire at some time prior to your next recredentialing date, you and/or your medical group/IPA will receive a request for updated information for your credentials file. Failure to provide this information within the specified time will result in automatic suspension and/or termination from the Molina Healthcare network.

G. Break in Contract

If a provider has a break in contract or service greater than 30 calendar days, Molina initially credentials that provider before the provider resumes seeing patients. The Credentialing Committee reviews all credentials and makes a final determination before the provider's re-entry into the network.

If Molina is unable to recredential a provider within 36-months because the provider is on active military assignment, maternity leave or sabbatical; but the contract between Molina and the provider remains in place, Molina will recredential the provider upon his or her return. Molina will document the reason for the delay in the provider's file. At a minimum, Molina will verify that a provider who returns has a valid license to practice before he or she can resume seeing patients. Within 60 days of notice when the provider resumes practice, Molina will complete the recredentialing cycle. If either party terminates the contract and there is a break in service of more than 30 days, Molina will initially credential the provider before the provider rejoins the network.

H. Provider's Rights during the Credentialing Process

1. Providers have the right to review their credential file

Providers have the right to review their credentials file at any time. The provider must notify the Credentialing Department and request an appointed time to review their file and allow up to

seven calendar days to coordinate schedules. A Medical Director and the Credentialing Director will be present. The provider has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied are the application, the license and the DEA certificate. Providers may not copy documents that include pieces of information that are confidential in nature, such as the provider credentialing checklist, the responses from monitoring organizations (i.e. National Provider Data Bank, State Licensing Board), and verification of hospital privileges letters.

2. Providers have the right to correct erroneous information

Providers have the right to correct erroneous information in their credentials file. Providers are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

Molina will notify the provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the provider. Examples include but are not limited to actions on a license, malpractice claims history or board certification decisions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

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

- Their requirement to submit a written response within 14 calendar days of receiving notification from Molina.
- In their response, the provider must explain the discrepancy, may correct any erroneous information and may provide any proof that may be available.
- Their response must be sent to:

**Molina Medicare of Utah
Attention: Credentialing Director
7050 Union Park Center, Suite 200
Midvale, Utah 48047**

Upon receipt of notification from the provider, Molina will document receipt of the information in the providers 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 providers credentials file. The provider will be notified in writing that the correction has been made to his/her credentials file. If the primary source information remains inconsistent with providers' notification, the Credentialing Department will notify the provider. The provider may then provide proof of correction by the primary source body to Molina's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the provider does not respond within 14 calendar days, his/her application processing will be discontinued and network participation will be denied.

3. Providers' right to be informed of their application status

Providers have a right, upon request, to be informed of the status of their application. Providers applying for initial participation are sent a letter when their application is received by Molina and are notified of their right to be informed of the status of their application in this letter.

The provider can request to be informed of the status of their application by telephone, mail or email. Molina will respond to the request within two working days. Molina may share with the provider where the application is in the credentialing process to include any missing information or information not yet verified. Molina does not share with or allow a provider to review references or recommendations, or other information that is peer-review protected.

I. Confidentiality

All provider information obtained during the credentialing process is private and confidential except where otherwise specified by law or at the discretion of the Credentialing Committee or the Molina Board. This policy includes both voting and non-voting members of the Credentialing Committee, invited guests of the Credentialing Committee and Molina Credentialing staff who is involved in the data collection and file preparation for the credentialing and recredentialing process.

Information, documents and/or evidence created, collected, maintained or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Committee or the Molina Board, in order to encourage candor and careful assessment necessary to effect peer review and quality assurance.

All members (voting and non-voting) and guests of the Credentialing Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality. Members and guests of the Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at Molina.

Credentials information is kept in a credentials file, filed by the providers' last name. Provider files are stored in locked file cabinets or locked rooms and are retained by Molina for 40 years following the end of the providers association with Molina.

The Director of Credentialing grants access to credentials files only as necessary to complete credentialing work or as required by law. Access to these documents will be restricted to authorized staff, Credentialing Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of Molina. Minutes, reports and files of Credentialing Committee meetings will be stored in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable laws.

Copies of minutes and any other related Credentialing Committee meeting materials will not be allowed to be removed from meetings of peer review committees and Credentialing staff will shred extra sets of information from such meetings. Electronic data and/or information are password protected and Molina Staff is advised not to divulge passwords to anyone including their co-workers.

J. Delegated Credentialing

Molina will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet Molina's requirements for delegation. Molina's Delegation Oversight Committee must approve all delegation and subdelegation arrangements, and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet Molina's requirements.

Molina's Credentialing Committee retains the right to approve new providers and provider sites and terminate or suspend providers, providers and sites of care based on requirements in Molina Credentialing Policy.

To be delegated for credentialing, IPAs and Provider Groups must:

- Be National Committee for Quality Assurance (NCQA) accredited for credentialing or pass Molina's credentialing delegation pre-assessment, which is based on NCQA credentialing standards and requirements for the Medicaid and Medicare programs.
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina at pre-assessment.
- Agree to Molina's contract terms and conditions for credentialing delegates.
- Submit timely and complete reports to Molina as described in policy and procedure.
- Comply with all applicable federal and state laws.
- If the IPA or Provider Group subdelegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA accredited in all ten areas of accreditation.

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

L. Providers opting out of Medicare

If a provider opts out of Medicare, that provider may not accept Federal reimbursement for a period of 2 years. Providers who are currently opted out of Medicare are not eligible to contract with Molina Healthcare for the Medicare line of business.

M. Corrective Action, Notification to Authorities and Provider Appeal Rights

Molina uses established criteria in the review of providers' performance. All adverse actions taken by the Credentialing Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986.

Molina providers who fail to meet the minimum credentialing standards or who fail to meet performance expectations pertaining to quality of patient care will be subject to corrective action, suspension or termination from network participation. This applies to all providers who are contracted by Molina. This policy does not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. The purpose of this policy is to provide a mechanism for implementation of corrective action, suspension or termination of Molina providers.

If at any point a provider fails to meet the minimum standards and criteria for credentialing, or fails to meet performance expectations with regard to quality of patient care, the Credentialing Committee may act to implement corrective action, suspend or terminate the provider's participation status. Suspension or Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the opportunity to appeal has been afforded to the provider.

Failure to meet expectations can be identified through activities, which include, but are not limited to:

- Recredentialing process
- Ongoing monitoring of sanctions, complaints and adverse events
- Quality/utilization review activities
- Medical record chart reviews
- Claims data review
- On site reviews, review of medical records, record keeping practices, patient safety procedures or other patient care and practice management functions.

1. Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, Molina may work with the provider to establish a corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

A corrective action plan is a written improvement plan, which may include, but is not limited to the following:

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected
- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six months)

Providers subject to corrective action will be notified within ten (10) working days, via a certified letter from the Medical Director. Such notification will outline:

- The reason for the corrective action
- The corrective action plan

If the corrective actions are resolved, the provider's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing Committee may recommend that the provider continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate provider response to corrective action will be brought to the Credentialing Committee for review and decision.

2. Summary Suspension

In cases where the Medical Director or the Credentialing Committee determines the circumstances pose an immediate risk to patients, a provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Medical Director shall promptly notify the provider of the suspension, via a certified letter. Notification will include the following:

- The action being taken
- The reason(s) for the action and/or information being investigated
- Information (if any) required from the provider
- The estimated timeline for determining whether or not to reinstate or terminate the provider
- The opportunity to a fair hearing (see Fair Hearing Plan policy)

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing Committee. The Credentialing Committee has the authority to implement corrective action, place conditions on the provider's continued participation, discontinue the suspension or terminate the provider.

3. Termination

After review of appropriate information, the Credentialing Committee may determine that the provider does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing Committee may then vote to terminate the provider. The effective date of the termination is determined by the contractual agreement between Molina and the affected provider. Within ten (10) business days of the Committee's decision, the provider is sent written notice of termination, via a certified letter from the Medical Director, which includes the following:

- Effective date of termination
- Reason for termination
- Obligations of the provider regarding further care of Molina patients/Members
- The opportunity to a fair hearing (see 5. Fair Hearing Plan policy below)

Termination criteria include but are not limited to the following:

- If a provider makes any material misstatements in, or omissions from their credentialing application and attachments.
- Provider's hospital privileges are refused, revoked, suspended, or reduced at any hospital.

- Provider's license or DEA certificate revoked, suspended, placed on probation or otherwise limited.
- Provider has been or is currently placed on probation, reprimanded, fined or has his/her practice restricted by any state agency in the United States that disciplines providers.
- Provider is or was censured or excluded (e.g. suspended or disqualified) by Medicare or Medicaid.
- Provider is indicted for or convicted of a felony.
- Provider fails to comply with Molina credentialing/recredentialing processes.
- Provider fails to comply with the provisions of his/her Molina contract.
- Provider renders or has rendered services outside the scope of his/her license.
- Provider fails to comply with procedures implemented in connection with the administration of utilization review or fails to cooperate with quality management.
- Provider has or has had a chemical dependency/substance abuse problem without verified evidence of successful treatment.
- Provider has a physical or mental health condition that may impair his/her ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
- Provider's failure to comply with the Molina Medical Record Review Guidelines.
- Provider's failure to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.
- Based on the judgment of the Credentialing Committee, provider has a malpractice claims history which establishes a potential risk to the quality of care or service delivered to Molina members
- Based on the judgment of the Credentialing Committee, any act, behavior or omission which establishes a potential risk to the quality of care or service delivered by the provider to Molina members.

4. Notification to Authorities

Molina reports to appropriate authorities whenever the Credentialing Committee takes or recommends any of the following Adverse Actions for a Provider based upon Unprofessional Conduct:

- Denial of initial application for Molina Provider status.
- Revocation, termination of, or expulsion from Molina Provider status.
- Reduction or revocation of authority to provide care to Molina patients.
- Suspension, reduction or revocation of authority to provide care to Molina patients for a cumulative period of more than thirty (30) days in any twelve (12) month period.
- Summary suspension of authority to provide care to Molina patients for more than fourteen (14) consecutive days.
- Any other final action by Molina that by its nature is reportable to the state licensing Board or the National Provider Data Bank.

When the Medical Director adopts a proposed action or recommendation of the Credentialing Committee for a Provider based on any the above adverse actions, a certified letter is sent to the provider describing the adverse action taken, the reason for the action and notifying the provider of his/her right to a Fair Hearing. A copy of the Fair Hearing Plan Policy is included

with the letter. The provider is given 30 days to request a Fair Hearing. The provider is notified of their right to be represented by an attorney or another person of their choice.

If the provider requests a Fair Hearing, the Molina Fair Hearing Plan Policy outlined below is followed. Within 15 days of the effective date of the action, the Molina Credentialing Department reports the action to the following authorities:

- State Licensing Board
- National Provider Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB)

Under State and Federal law, certain procedural rights shall be granted to a provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board and/or the National Provider Data Bank (NPDB).

N. Fair Hearing Plan Policy

Molina Healthcare will maintain and communicate the process providing procedural rights to providers when a final action of Molina will result in a report to the Licensing Board and/or the NPDB.

1. Definitions

- a. Adverse Action is an action which would entitle a Provider to a hearing, as set forth in Section B (1)-(6) below.
- b. Molina Provider is a health care provider who is eligible to provide care to Molina enrollees by virtue of (1) a contract with Molina to provide such care and (2) having been credentialed by Molina or its designee to provide such care.
- c. Days as used in this Policy, shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.
- d. Unprofessional Conduct shall mean a basis for corrective action involving an aspect of a Provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care.
- e. Notice means written notification sent by certified or registered mail, return receipt requested or personal delivery.
- f. Credentialing Committee or Professional Review Committee as used in this Policy, shall mean an Molina committee or the designee of such a committee.
- g. Provider for purpose of this Policy includes a health care provider with Molina Provider status as well as those who are applicants for Molina Provider status.

2. Grounds for a Hearing

Grounds for a hearing exist whenever the Credentialing Committee or Professional Review Committee takes or recommends any of the following Adverse Actions for a Provider based upon Unprofessional Conduct:

- a. Denial of initial application for Molina Provider status.
- b. Revocation, termination of, or expulsion from Molina Provider status.
- c. Reduction or revocation of authority to provide care to Molina patients.

- d. Suspension, reduction or revocation of authority to provide care to Molina patients for a cumulative period of more than thirty (30) days in any twelve (12) month period.
- e. Summary suspension of authority to provide care to Molina patients for more than fourteen (14) consecutive days.
- f. Any other final action by Molina that by its nature is reportable to the Licensing Board or the NPDB.

3. Notice of Action

If the Credentialing Committee and/or Professional Review Committee has recommended an Adverse Action, the Committee shall give written notice to the Provider by certified mail with return receipt requested. Notice shall:

- a. Describe the nature of the proposed action or recommendation.
- b. State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal law.
- c. Advise the Provider that he/she has the right to request a hearing on the proposed Adverse Action.
- d. Inform the Provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action and must be sent to the Medical Director.
- e. Inform the Provider that they may be represented by an attorney or another person of their choice.
- f. Inform the Provider the request for a hearing must be accompanied by a check in the amount of \$1,000 as a deposit for the administrative expenses of the hearing.
- g. Contain a summary of the Provider's Hearing Rights or attach this Policy.

4. Request for a Hearing - Waiver

If the Provider does not request a hearing in writing to the Medical Director within thirty (30) days following receipt of the Notice of Action, the Provider shall be deemed to have accepted the action or recommendation of the Credentialing Committee and/or Professional Review Committee, and such action or recommendation shall be submitted to the Medical Director for final decision. In the event that a timely written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Credentialing Committee and/or Professional Review Committee shall provide the Provider with a Notice of Hearing and Statement of Charges consistent with this Policy.

A Provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing or appellate review to which he or she might otherwise have been entitled. If the Provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Credentialing Committee and/or Professional Review Committee taking or recommending the Adverse Action shall be forwarded to the Medical Director for final approval. In the event of a submittal to the Medical Director upon the Provider's waiver as set forth herein, the Credentialing Committee and/or Professional Review Committee may submit to the Medical Director additional information relevant to its recommended Adverse Action to be considered by the Medical Director in accepting or rejecting the recommended Adverse Action.

5. Appointment of a Hearing Committee

a. Composition of Hearing Committee

The Medical Director shall select the individuals to serve on the Hearing Committee. The Hearing Committee shall consist of individuals who are not in direct economic competition with the subject Provider; who shall gain no direct financial benefit from the outcome of the Hearing; and, who shall have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. General knowledge of the matter involved shall not preclude a physician from serving as a member of the panel.

The panel shall consist of at least three, but no more than five, Providers and shall include, whenever feasible, at least one individual practicing the same specialty as the affected Provider. In the event Providers are not available to sit as Hearing Committee members, physicians from the community may be substituted by the Medical Director.

b. Scope of Authority

The Hearing Committee shall have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.

c. Responsibilities

The Hearing Committee shall:

- Evaluate evidence and testimony presented.
- Decide whether to accept, reverse or modify the decision of the Credentialing Committee and/or Professional Review Committee.
- Maintain the privacy of the hearing unless the law provides to the contrary.

d. Vacancies

In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.

e. Disclosure and Challenge Procedures

Any person appointed to the Hearing Committee shall disclose to the Medical Director any circumstance likely to affect impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives.

6. Hearing Officer

a. Selection

As soon as reasonably possible, the Medical Director shall appoint a Hearing Officer, who may be an attorney. The Hearing Officer shall gain no direct financial benefit from the outcome of the Hearing, shall not act as a prosecuting officer or advocate and shall not be entitled to vote.

b. Scope of Authority

The Hearing Officer shall have the sole discretion and authority to:

- Exclude any witness, other than a party or other essential person.

- Determine the attendance of any person other than the parties and their counsel and representatives.
 - For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative, and shall also grant such postponement when all of the parties agree thereto.
- c. Responsibilities
- The Hearing Officer shall:
- Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner.
 - Ensure that proper decorum is maintained.
 - Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing.
 - Make all rulings and questions which pertain to matters of law, procedure and the admissibility of evidence.

If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action deemed warranted by the circumstances. If requested by a Hearing Committee, the Hearing Officer may participate in the deliberations of the Hearing Committee and be a legal advisor to it, but shall not be entitled to vote.

7. Time and Place of Hearing

Upon receipt of a Request for Hearing, the Medical Director shall schedule and arrange for a Hearing. The Medical Director shall give notice to the affected Provider of the time, place and date of the Hearing, as set forth below. The date of commencement of the Hearing shall be not less than thirty (30) days from the date of the Notice of the Hearing, nor more than sixty (60) days from the date of receipt of the Request for Hearing. Notwithstanding the above time frames, the parties may agree to extensions or the Hearing Officer may grant an extension on a showing of good cause. If more than one meeting is required for a Hearing, the Hearing Officer shall set the date, time, and location for additional meetings.

8. Notice of Hearing

The Notice of Hearing shall contain and provide the affected Provider with the following:

- a. The date, time and location of the Hearing.
- b. The name of the Hearing Officer.
- c. The names of the Hearing Committee Members.
- d. A concise statement of the affected Provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the Hearing.
- e. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Credentialing Committee and/or Professional Review Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the Hearing.

- f. A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the Provider to prepare a defense, including all documentary evidence which was considered by the Credentialing Committee and/or Professional Review Committee in recommending Adverse Action.

Except with regard to the disclosure of witnesses as set forth above, the Notice of Hearing may be amended from time to time but no later than the close of the case at the conclusion of the Hearing by the Hearing Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

9. Pre-Hearing Procedures

- a. The Provider shall have the following pre-Hearing rights:
 - To inspect and copy, at the Provider's expense, documents upon which the charges are based which the Credentialing Committee and/or Professional Review Committee has in its possession or under its control.
 - To receive, at least thirty (30) days prior to the Hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the Provider to prepare a defense, including all evidence which was considered by the Credentialing Committee and/or Professional Review Committee in recommending Adverse Action.
- b. The Hearing Committee shall have the following pre-Hearing right:

To inspect and copy, at Molina's expense, any documents or other evidence relevant to the charges which the Provider has in his or her possession or control as soon as practicable after receiving the request.
- c. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:
 - Whether the information sought may be introduced to support or defend the charges.
 - The exculpatory or inculpatory nature of the information sought, if any.
 - The burden attendant upon the party in possession of the information sought if access is granted.
 - Any previous requests for access to information submitted or resisted by the parties.
- d. The Provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.
- e. It shall be the duty of the Provider, the Credentialing Committee and/or Professional Review Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled Hearing as possible, in order that decisions concerning such matters may be made in advance of the Hearing. Objections to any pre-Hearing decisions may be succinctly made at the Hearing.
- f. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the Hearing shall constitute

good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.

- g. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the Provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of applicable law.

10. Conduct of Hearing

- a. Rights of the Parties - Within reasonable limitations and as long as these rights are exercised in an efficient and expeditious manner, both sides at the Hearing may:
 - Call and examine witnesses for relevant testimony.
 - Introduce relevant exhibits or other documents.
 - Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
 - Otherwise rebut evidence.
 - Have a record made of the proceedings.
 - Submit a written statement at the close of the Hearing.
 - Receive the written recommendation of the Hearing Officer or Hearing Panel, including a statement of the basis for the recommendations, upon completion of the Hearing.

The Provider may be called by the Credentialing Committee and/or Professional Review Committee and examined as if under cross-examination.

- b. Course of the Hearing
 - Each party may make an oral opening statement.
 - The Credentialing Committee and/or Professional Review Committee shall call any witnesses and present relevant documentary evidence to support its recommendation. The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.
 - The Hearing Committee or Officer has the discretion to vary this procedure but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.
 - The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except where agreed to by the parties or determined by the Hearing Officer.
- c. Use of Exhibits
 - Exhibits, when offered by either party, may be received in evidence by the Hearing Committee as ruled upon by the Hearing Officer.
 - A description of the exhibits in the order received shall be made a part of the record.
- d. Witnesses
 - Witnesses for each party shall submit to questions or other examination.

- The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.
 - The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.
 - The party producing such witnesses shall pay the expenses of their witnesses.
- e. Rules for Hearing
- Attendance at Hearings - Only those persons having a direct interest in the Hearing are entitled to attend the Hearing. This means that the Hearing will be closed except for the parties and their representatives. The only exception to this being when good cause is shown which is satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the Hearing to have others present.
 - Communication with Hearing Committee - There shall be no direct communication between either party and the Hearing Committee other than at the Hearing, unless the parties and the Hearing Committee agree otherwise. Any other oral or written communication from the parties to the Hearing Committee shall be directed to the Hearing Officer for transmittal to the Hearing Committee.
 - Interpreter - Any party wishing an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

f. Close of the Hearing

At the conclusion of the Hearing, the Hearing Committee shall dismiss all parties and deliberate. Within thirty (30) days of the conclusion of the Hearing, the Hearing Committee shall render a written decision and report, including findings of fact and a conclusion articulating the connection between the evidence produced at the Hearing and the decision reached. The decision of the Hearing Committee will be made by majority vote.

Final adjournment of the Hearing shall occur when the Hearing Committee has mailed or otherwise delivered a written decision.

g. Burden of Proof

In all Hearings it shall be incumbent on the Credentialing Committee and/or Professional Review Committee taking or recommending an Adverse Action to come forward initially with evidence in support of its action or decision. Thereafter, the Provider who requested the Hearing shall come forward with evidence in his/her support. The burden of proof during a Hearing shall be as follows:

- Burden - Initial Applicant

A Provider who requested the Hearing to challenge a recommendation to deny an application for Molina Provider status (initial applicant) shall have the burden of persuading the Hearing Committee, by a preponderance of the evidence, that the Recommendation for Adverse Action lacks any substantial factual basis or that the conclusions drawn from there are arbitrary and capricious. The initial applicant shall

not be permitted to introduce information during a Hearing that was not produced to Molina during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

- **Burden - All Others**
The Credentialing Committee or Professional Review Committee taking or recommending the Adverse Action shall bear the burden of persuading the Hearing Committee, by clear and convincing evidence, that its action or recommendation is reasonable and warranted. The term “reasonable and warranted” means within the range of alternatives reasonably available to the Credentialing Committee and/or Professional Review Committee taking or recommending Adverse Action under the circumstances and not necessarily that the action or recommendation is the only measure or the best measure that could have been taken or formulated.
- h. **Provider Failure to Appear or Proceed**
Failure, without good cause, of the Provider to personally attend and proceed at a Hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.
- i. **Record of the Hearing/Oath**
A court reporter shall be present to make a record of the Hearing proceedings and the pre-Hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by Molina, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.
- j. **Representation**
Both parties shall be entitled to be accompanied by an attorney at law, or other representative at the Hearing to represent its interests, to present its case, offer materials in support thereof, examine witnesses, and respond to appropriate questions.
- k. **Postponements**
The Chair of the Hearing Committee, for good cause shown, may postpone any Hearing upon the request of a party or upon the Hearing Committee’s own initiative and shall also grant such postponement when all of the parties agree thereto.
- l. **Notification of Finding**
The Hearing Committee shall make its decision along with a report outlining the basis of its decision to the Medical Director, the Credentialing Committee and/or Professional Review Committee imposing the action, and the affected Provider.
- m. **Final Decision**
Upon receipt of the Hearing Committee’s decision, the Medical Director shall either adopt or reject the Hearing Committee’s proposed decision. The Medical Director’s action constitutes the Final Decision.

n. Reporting

In the event the Medical Director adopts the proposed action or recommendation of the Credentialing Committee and/or Professional Review Committee taking or recommending the Adverse Action, Molina will submit a report to the State Licensing Board and/or the National Provider Data Bank (NPDB), if applicable. Reports shall be made in accordance with the Credentialing Program Policy.

o. Exhaustion of Internal Remedies

If any of the above Adverse Actions are taken or recommended, the Provider must exhaust the remedies afforded by these procedures before resorting to legal action.

XIV. Member Grievances and Appeals

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

A. Complaints, Grievances and Appeals Process

- 1. Complaints** - may be either grievances or appeals or both and may be processed under one or both procedures. The Appeal and Grievance Form provided at the end of this section is completed by the Member or representative when filing and submitting a grievance or appeal.

Each issue is adjudicated separately. **Complaints or disputes involving organization determinations are processed as appeals.** All other issues are processed as grievances. General guidelines that are used to determine the category of the complaint are:

- The grievance process will be used for complaints concerning disenrollment, cost sharing, changes in premiums, and access to a Provider or Molina Medicare
 - Changes in Provider availability to a specific beneficiary will be considered an organization determination.
 - The QIO process is used for complaints regarding quality of medical care.
- 2. Grievances** – Grievance procedures are as follows:
 - Molina Medicare will accept any information or evidence concerning the grievance orally or in writing not later than 60 days after the event and will thoroughly investigate, track and process the grievance within 30 days unless an extension is granted.
 - If Molina Medicare extends the time necessary or refuses to grant an organization determination or reconsideration Molina Medicare will respond to the beneficiary within 24 hours.
 - Complaints concerning the timely receipt of services already provided are considered grievances.
 - 3. Quality of Care**

Most quality of care complaints are treated as grievances however, quality of care complaints that involve denials are considered to be organization determinations.
 - 4. Organization Determination**

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

Molina Medicare's Utilization Management Department handles organization determination. Organization Determination is discussed in Section VII., O – Utilization Management. Any party to an organizational determination, i.e., a Member, a Member's representative or a non-contracted physician or Provider, or a termination of services decision, may request that the

determination be reconsidered. However, contracted Providers do not have appeal rights. A Member or Member’s representative are the only parties who may request that Molina Medicare reconsider a denial or modification decision.

Organization determinations are either standard or expedited depending on the urgency of the beneficiary’s request.

5. Non-Formulary Appeals

If a Member is denied a service or a service is reduced or appointment times are excessive a Member may appeal. Members may choose someone, including an attorney or Provider, to serve as their personal representative to act on their behalf. After the date of the denial, a Member has up to 90 days to file an appeal. Appeal data is confidential. The appeal will be acknowledged within 5 days and will be responded to within 14 days; unless Molina Medicare notifies the Member in writing that more time is needed.

In all cases, appeals will be resolved within 30 days. If an expedited appeal is required for an emergent situation, then the decision will be made within 72 hours of the request. At any time during the appeal process the Member or personal representative may submit written comments, papers or other data about the appeal in person, as well as in writing. An independent review must be requested within 60 days by the Member.

The independent review request will be sent by Molina Medicare to the Independent Review Entity (IRE) within three working days of receipt. The IRE usually makes a decision within 15 days. Molina Medicare will communicate the outcome to the Member. When an expedited review is requested the IRE will make a decision within 72 hours. There is no cost to the Member for an independent review. If the IRE changes the Molina Medicare decision, the claim will be paid or approval updated within 15 business days.

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

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

Appeal:	Any of the procedures that deal with the review of adverse organization determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by Molina Medicare and if necessary, an independent review entity, hearing before an Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.
Assignee	A non-contracted physician or other non-contracted Provider who has furnished a service to the Member and formally agrees to waive any right to payment from the Member for that service.

Complaint	Any expression of dissatisfaction to Molina Medicare, Provider, facility or Quality Improvement Organization (QIO) by a Member made orally or in writing. This can include concerns about the operations of Providers or Molina Medicare such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to Members, the claims regarding the right of the Member to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the Member believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.
Coverage Determination: Denial Notices	A written denial notice by a Molina Medicare that states the specific reasons for the denial and informs the Member of his or her right to a reconsideration. The notice describes both the standard and expedited appeals processes and the rest of the appeals process. For payment denials, the notice describes the standard redetermination process and the rest of the appeals process.
Effectuation	Compliance with a reversal of Molina Medicare's original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.
Member	A Medicare-eligible individual who has elected a Medicare plan offered by an MA organization, or a Medicare eligible individual who has elected a cost plan or HCPP.
Independent Review Entity	An independent entity contracted by CMS to review Molina Medicare's adverse reconsiderations of organization determinations.
Inquiry:	Any oral or written request to a Molina Medicare, Provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by a Member.
Medicare Plan:	A plan defined in 42 CFR. 422.2 and described at 422.4.
Organization Determination	Any determination made by Molina Medicare with respect to any of the following: <ul style="list-style-type: none"> • Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services, • Payment for any other health services furnished by a Provider other than a Molina Medicare Provider that the Member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Molina Medicare. • Molina Medicare's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by the Medicare health plan, • Discontinuation of a service if the Member believes that continuation of the services is medically necessary, or • Failure of Molina Medicare to approve, furnish, arrange for, or

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

C. Important Information about Member Appeal Rights

For information about Member's appeal rights, call the Molina Medicare Member Service Department Monday through Sunday 8:00 a.m. to 8:00 p.m.

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

There Are Two Kinds of Appeals You Can File:

Standard Appeal (30 day) – You can ask for a standard appeal. Your plan must give you a decision no later than 30 days after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if it needs additional information and the extension benefits you.)

Fast (72-hour review) – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide on a fast appeal no later than 72 hours after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if it needs additional information and the extension benefits you.)

If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, your plan will automatically give you a fast appeal. If you ask for a fast appeal without support from your doctor, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal in 30 days

What do I include with my Appeal?

You should include your name, address, Member ID number, reason for appealing and any evidence you wish to attach. You may send in supporting medical records, doctor’s letter(s), or other information that explains why your plan should provide service. Call your doctor if you need this information to help with your appeals.

How do I file an Appeal?

For Standard Appeal: you or your authorized representative should mail or deliver your written appeal to Molina Medicare at:

Molina Medicare
P.O. Box 8542
Midvale, Utah 84047

For Fast Appeals: You or your authorized representative should contact us by telephone or fax using the information indicated on the Appeals and Grievance Form.

To file an oral grievance call us at:
1-888-665-1328. Hours of Operation:
Monday through Sunday 8:00 a.m. to 8:00 p.m.. TTY/TDD access number is **1-800-346-4128**.

Fax Number: **1-801-858-0409**

Other resources:
Medicare Rights Center:
1-888-HMO-9050
1-800-MEDICARE (1-800-633-4227)

If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.

XV. Organization Determination – Medicare Part D

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

Any party to an organizational determination, i.e., a Member, a Member's representative may request that the determination be reconsidered. A Member, a Member's representative, or physician are the only parties who may request that Molina Medicare expedite a coverage determination or redetermination. The member's physician is prohibited from requesting a standard redetermination or higher appeal without being the member's appointed representative.

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

A. Appeals / Redeterminations

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

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

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

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

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

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

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

B. Part D Prescription Drug Exception Policy

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

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

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

Part D Exceptions and Appeals Contact Information:

Molina Medicare 888 483-0760

Phone 0012 888-665-1328

Fax 0911 866-450-3914

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

1. Formulary

A formulary is a list of medications selected by Molina Medicare in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Molina Medicare will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Molina Medicare network pharmacy, and other plan rules are followed.

Formularies may be different depending on the Molina Medicare Plan and will change over time. Current formularies for all products may be downloaded from our Website at www.molinamedicare.com.

Molina Medicare is contracted with the Rx America network to provide prescription drugs to our Members.

The amount a patient pays depends on which drug tier the drug is in under the plan and whether the patient fills the prescription at a preferred network pharmacy.

2009 Drug Tier for Molina Medicare of Utah	2009 Options (Medicare Prescription Drug Plan)	2009 Options Plus (Special Needs Plan)
Formulary Generic Tier One	\$ 5.00	\$0
Formulary Preferred Brand – Tier Two	\$ 20.00	\$3.20 - \$6.00 depending on LIS level
Formulary Non-Preferred Brand-Tier three	\$ 50.00	\$3.20 - \$6.00 depending on LIS level
Specialty Drugs-Tier 4	33%	\$3.20 - \$6.00 depending on LIS level

*Please note: At CMS’s discretion, copayments and/or benefit design may change at the beginning of the next contract year, and each year thereafter.

- All Part D services have a copayment.
- Copayments cannot be waived by Molina Medicare, per the Centers for Medicare & Medicaid Services.
- Copayments for patients in other Molina Medicare plans may differ by state and program.
- Non Covered Molina Medicare Part D Drugs:
- Agents when used for anorexia, weight loss, or weight gain (no mention of medically necessary)
- Agents when used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Agents used for symptomatic relief of cough or colds
- Prescription Vitamins and minerals, except those used for prenatal care and fluoride preparations.
- Non-prescription drugs, except those medications listed as part of Molina Medicare’s over-the-counter (OTC) monthly benefit
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale
- Barbiturates (e.g., phenobarbital)
- Benzodiazepines (Valium, Restoril,)
- Molina members with Medicaid coverage may have a limited selection of these excluded medications as part of its Medicaid coverage for Members assigned to Molina Medicaid.

2. Restrictions on Molina Medicare drug coverage

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Molina Medicare requires prior authorization for certain drugs, some of which are on the formulary and also drugs that are not on the formulary. Without prior approval, Molina Medicare may not cover the drug.
- **Quantity Limits:** For certain drugs, Molina Medicare limits the amount of the drug that it will cover.
- **Step Therapy:** In some cases, Molina Medicare requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, Molina Medicare may not cover drug B unless drug A is tried first.
- **Part B medications:** Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration.

3. There may be differences between the Medicare and Medicaid Formularies

The Molina Medicare Formulary includes many injectable drugs not typically found in its Medicaid formularies such as those for the aged, blind and disabled.

4. Requesting a Molina Medicare Formulary Exception

Molina Medicare product drug prior authorizations are called “Exceptions,” which are required when your patient needs a drug that is not on the Formulary. A Member, a Member’s appointed representative or a Member’s prescribing physician are permitted to file an Exception. (The process for filing an exception is predominantly a fax based system.) The form for exception requests is available from the www.molinamedicare.com web site.

5. Requesting a Molina Medicare Formulary Redetermination (Appeals)

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

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

- A standard appeal may be submitted to Molina Medicare in writing or can be taken over the phone. The appeal will be reviewed upon receipt and the Member will be notified in writing within seven calendar days from the date the request for redetermination is received.
- An expedited appeal can be requested orally or in writing by the Member or by a physician acting on behalf of the Member. An expedited appeal may be requested in situations where applying the standard time frame could seriously jeopardize the

Member's life, health or ability to regain maximum function. If a physician supports the request for an expedited appeal, Molina Medicare will honor this request.

- If a Member submits an appeal without physician support, Molina Medicare will review the request to determine if it meets Medicare's criteria for expedited processing. If the plan determines that the request meets the expedited criteria, Molina Medicare will render a decision as expeditiously as the Member's health requires, but not exceeding 72 hours. If the request does not meet the expedited criteria, Molina Medicare will render a coverage decision within the standard redetermination time frame of seven calendar days.
- To submit a verbal request, please call **888-665-1328**. Written appeals must be mailed or faxed to **866-450-3914**. See contact information above.

6. Initiating a Part D Exception (Prior Authorization) Request

Molina Medicare will accept requests from Providers or a pharmacy on the behalf of the prescriber either by a written or verbal request. The request may be communicated through the standardized "Molina Medicare Medication Prior Authorization Request Form" or through telephone via fax and phone lines. All requests will be determined and communicated to the Member and the Member's prescribing physician with an approval or denial decision within 72 hours (3 calendar days) after Molina Medicare receives the "completed request."

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

- a. A prescription drug is a Part D drug only if it is for a "medically accepted" indication, which is supported by one or more citations included or approved for inclusion with the following compendia:
 - American Hospital Formulary Service Drug Information
 - United States Pharmacopeia-Drug Information
 - DRUGDEX Information System
 - American Medical Association Drug Evaluations
 - NCCN
 - Micromedex Drug Dex
 - Elsevier Clinical Pharmacology
- b. Requests for off-label use of medications will need to be accompanied with excerpts from one of the seven CMS-required compendia for consideration. The submitted excerpts must site a favorable recommendation.

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

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

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

If a coverage determination is expedited, Molina Medicare will notify the Member of the coverage determination decision within the 24-hour timeframe by telephone and mail the Member a written Expedited Coverage Determination within three calendar days of the oral notification.

If Molina Medicare does not give the Member a written notification within the specified timeframe, Molina Medicare will start the next level of appeal by sending the Coverage Determination request to the Independent Review Entity (IRE) within 24 hours.

7. Initiating a Part D Appeal

If Molina Medicare's initial coverage determination is unfavorable, a Member may request a first level of appeal, or re-determination within 60 calendar days from the date of the notice of the coverage determination. In a Standard Appeal Molina Medicare has up to seven days to make the re-determination, whether favorable or adverse, and notify the Member in writing within seven calendar days from the date the request for re-determination is received.

Members or a Member's prescribing physician may request Molina Medicare to expedite a re-determination if the standard appeal timeframe of seven days may seriously jeopardize the Member's life, health, or ability to regain maximum function. Molina Medicare has up to 72 hours to make the re-determination, whether favorable or adverse, and notify the Member in writing within 72 hours after receiving the request for re-determination. If additional information is needed for Molina Medicare to make a re-determination, Molina Medicare will request the necessary information within 24 hours of the initial request for an expedited re-determination. Molina Medicare will inform the Member and prescribing physician of the conditions for submitting the evidence since the timeframe is limited on expedited cases.

The Part D Independent Review Entity (IRE)

If the re-determination is unfavorable, a Member may request reconsideration by the IRE. The Part D Qualified Independent Contractor (IRE) is currently MAXIMUS Federal, a CMS contractor that provides second level appeals.

- Standard Appeal: The IRE has up to seven days to make the decision.
- Expedited Appeal: The IRE has up to 72 hours for to make the decision.
- Administrative Law Judge (ALJ): If the IRE's reconsideration is unfavorable, a Member may request a hearing with an ALJ if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable on this level of appeal.
- Medicare Appeals Council (MAC): If the ALJ's finding is unfavorable, the Member may appeal to the MAC, an entity within the Department of Health and Human Services that reviews ALJ's decisions. Note: Regulatory timeframe is not applicable on this level of appeal.
- Federal District Court (FDC): If the MAC's decision is unfavorable, the Member may appeal to a Federal district court, if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable on this level of appeal.

XVI. Glossary

Term	Definition
Appeal	A complaint lodged by a Member if they disagree with certain kinds of decisions made by the health plan.
Case Management	A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to accommodate the specific health services needed by an individual.
Claim	A request for payment for the provision of Covered Services prepared on a HCFA 1500 form, UB-92, or successor.
CMS	Centers for Medicare and Medicaid Services
Coinsurance	The amount a Member pays for medical services after the deductible is paid. Coinsurance amounts are usually percentages of approved amounts.
Copayment or Copay	The amount a Member pays for medical services such as a doctor's visit or prescription.
Deductible	The amount a Member pays for health care or prescriptions, before the health plan begins to pay.
Disenroll	Ending health care coverage with a health plan.
Division of Financial Responsibility (DOFR)	A document whereby health plans assign the payment risk for any contract, dividing payment responsibilities among the plan itself, the contracted hospital, or a Medical Group/IPA.
Durable Medical Equipment (DME)	Purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care Provider to be used in a patient's home.
Eligibility List	A list of Members that are assigned to Primary Care Physicians through a Medical Group, IPA or Staff Model Organization.
Emergency Services/Care	Care given for a medical emergency when a Member believes that his/her health is in serious danger when every second counts.
Encounter Data	Claims data for services rendered to Members who are assigned to a Primary Care Physicians through a capitated Medical Group or IPA, or Staff Model Organization.
Enrollment	The process by which an eligible person becomes a Member of a managed care plan.
EOB	Explanation of Benefits.
Experimental	Items and procedures determined by Medicare not to be generally accepted by the medical community.
Formulary	A list of certain prescription drugs that the health plan will cover subject to limits and conditions.
Grievance	A complaint about the way a Medicare health plan is giving care.
Health Maintenance Organization Plan	A type of Medicare Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most

Term	Definition
	HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. HMO costs may be lower than in the Original Medicare Plan..
Home Health Agency	An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.
Hospice Services	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling.
Institution	A facility that meets Medicare's definition of a long-term care facility, such as a nursing home or skilled nursing facility. Assisted or adult living facilities, or residential homes, are not included.
IPA (Independent Practice Association)	An IPA is an association of physicians and other health care Providers, including hospitals, who contract with HMOs to provide services to the HMO Members, but usually also see non-HMO patients.
Long-Term Care	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare does not pay for this type of care if this is the only care needed.
Managed Care	Managed Care Organizations are entities that serve Members on a risk basis through a network of employed or affiliated Providers. This includes Health Maintenance Organizations (HMOs), Competitive Medical Plans (CMPs), and other plans that provide health services on a prepayment basis, which is based either on cost or risk, depending on the type of contract they have.
Medicaid	A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if a Member qualifies for both Medicare and Medicaid.
Medically Necessary	Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the Member or the doctor.
Medicare (Original Medicare)	A pay-per-visit health plan that lets Members go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. Members must pay the deductible. Medicare pays its share of the Medicare-approved amount, and Members pay a share (coinsurance). In some cases Members may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
Medicare Plan	A plan offered by a private company that contracts with Medicare to provide Members with all Medicare Part A and Part B benefits. In most cases, Medicare Plans also offer Medicare prescription drug coverage.

Term	Definition
Member	A Medicare-eligible individual who is eligible and enrolled in a Molina Medicare health plan.
Network	A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its Members.
Participating Provider	Participating Providers agree to accept a pre-established approved amount as payment in full for service. Provider is used as a global term to include all types of Providers/practitioners.
Primary Care Physician (PCP)	A Provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants) who manages, coordinates, and monitors covered primary care (and sometimes additional services).
Quality Improvement (QI)	Program provides structure and outlines specific activities designed to improve the care, service and health of Molina Medicare Members.
Service Area	The area where a health plan accepts Members. For plans that require participating doctors and hospitals to be used, it is also the area where services are provided. The plan may disenroll Members who move out of the plans service area.
Skilled Nursing Facility (SNF)	A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.
Skilled Nursing Facility Care	This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff and that, as a practical matter, can't be provided on an outpatient basis.
Special Needs Plan	A special type of plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, or those who reside in a nursing home.
TTY	A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe-speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.
Urgently Needed Services	Care that Members get for a sudden illness or injury that needs medical care right away, but is not life threatening. Primary care physicians generally provide urgently needed care if the Member is in a Medicare health plan other than the Original Medicare Plan. If a Member is out of the plan's service area for a short time and cannot wait until the return home, the health plan must pay for urgently needed care.