NURSING FACILITY PROVIDER MANUAL

(Provider Handbook)

Molina Healthcare of Texas, Inc.

(Molina Healthcare or Molina)

STAR+PLUS | Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Tarrant, MRSA Northeast

MMP | Bexar, Dallas, El Paso, Harris, Hidalgo

2024

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Molina Healthcare. "Molina Healthcare" or "Molina" have the same meaning as "Health Plan" in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com or by calling (855) 322-4080.

Last Updated: 01/2024

TEXAS Health and Human Services | TEXAS STAR PLUS Your Health Plan ★ Your Choice | TEXAS Medicare Medicaid PLAN Your Health Plan ★ Your Choice

MOLINA® HEALTHCARE

Table of Contents

Introduction

Background

Molina Healthcare of Texas (Molina) is a for-profit corporation in the State of Texas, and a subsidiary of Molina Healthcare, Inc. is a Fortune 500 company and provides managed health care services under the Medicaid and Medicare programs and through the state insurance Marketplace. What started in 1980 as one clinic in Long Beach, aimed at addressing the disparities in access to quality health care, has grown into 19 health plans serving over 5 million members across the country.

Molina has been serving communities in Texas since 2006 and is dedicated to taking care of even the most vulnerable populations, including elderly members and members with disabilities. We do this by offering a holistic, community-based approach designed specifically to meet the individual needs of our members. Molina operates in 8 services areas across the state. Under Texas Medicaid, Molina offers STAR and STAR+PLUS plans. Molina also offers the Children's Health Insurance Plan (CHIP), the Medicare-Medicaid Plan (MMP), Medicare and Health Insurance Marketplace plans.

Continuing the Vision

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

Vision Statement

We will distinguish ourselves as the low cost, most effective and reliable health plan delivering government-sponsored care.

Core Values

Integrity Always
Absolute Accountability
Supportive Teamwork
Honest and Open Communication
Member and Community Focused

Quick Reference Guide

Provider Services/Relations (Medicaid & MMP) • Claims Status, Complaint & Appeals Status • Member Eligibility, Benefit Verification • Utilization Management, Quality Improvement • Prior Authorization, Referrals	(855) 322-4080 MTHXProviderServices@MolinaHealthcare.com Nursing Facilities: NFProviderServices@Molinahealthcare.com
Provider Online Portal Relations (Medicaid & MMP) • Member Eligibility • Claims Submission and Status • Authorization Request Submission and Status • HEDIS Scores	https://provider.molinahealthcare.com/Provider/Login
Behavioral Health Services (Medicaid & MMP) Crisis Hotline Behavioral Health Services	(800) 818-5837 (866) 449-6849
Contracting (Medicaid & MMP) • How to join the network • Contract Clarifications • Fee Schedule Inquiries	Texasexpansioncontracting@molinahealthcare.com
Provider Complaints and Appeals (Medicaid & MMP)	Phone: (866) 449-6849/ Fax: (877) 319-6852 Molina Healthcare of Texas Attn: Provider Complaints & Appeals P.O. Box 182273 Chattanooga, TN 37422
Electronic Claims Submission Vendors (Medicaid & MMP) Availity, Zirmed, Practice Insight, SSI & Change Healthcare	Payor Identification for All: 20554
Paper & Corrected Claims (Medicaid & MMP)	P.O. Box 22719 Long Beach, CA 90801
Pharmacy (Medicaid & MMP) Prior Authorizations, Assistance/Inquiries	(866) 449-6849 (Voice) (888) 487-9251 (Fax)
24-hour Nurse Advice Line (Medicaid & MMP) Clinical Support for Members	(888) 275-8750 (English) (866) 648-3537 (Spanish)
STAR+PLUS Service Coordination	(866) 409-0039
LTSS Rate Grid	www.MolinaHealthcare.com
Member Services (Medicaid)	(866) 449-6849 (877) 319-6826 (CHIP Rural Service Area)
Enrollee Services (MMP)	(866) 856-8699
Medicaid Managed Care Helpline	(866) 556-8989
Compliance/Anti-Fraud Hotline (Medicaid & MMP)	(866) 655-4626 https://molinahealthcare.alertline.com

Chapter 1 – Objectives and Roles

Objectives of Programs

The objectives of the STAR+PLUS program are to:

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

The objectives of the Medicare Medicaid Program (MMP) are to:

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

Roles

Role of Nursing Facility

- Provide member access to 24-hour Nursing Facility (NF) Services
- Coordinate care with the member assigned Primary Care Provider and Nursing Facility staff
- Provide services as needed as identified in the Minimum Data Set (MDS) based upon the NF plan of care
- Work in a collaborative effort with the Service Coordinator to meet the NF Member needs
- Provide/contract for STAR+PLUS Add-On Services and MMP services
- Provide member access to hospice services as needed

Role of the Primary Care Provider

Primary Care Providers (PCP) participating in the Texas Medicaid program practice the “medical home concept”. The providers in the medical home are knowledgeable about the individual’s and family’s specialty care and health-related social and educational needs and are connected

with necessary resources in the community that will assist the family in meeting those needs. When referring for consultation, to specialists, network facilities and contractors, health and health- related services, the medical home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism, and accepts them back into the medical home for continuing primary medical care and preventive health services.

Role of Specialty Care Provider

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

Specialist as a PCP

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

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

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

Role of the STAR+PLUS & MMP Service Coordinator

The Service Coordinator (SC) is to partner with NF care coordinators and other NF staff to ensure members' care is holistically integrated and coordinated to find ways to avoid preventable hospital admissions, readmissions, and emergency room visits. The SC participates in person and family-centered service planning with the NF staff, primary care provider, vendors, and other state and community agencies to coordinate managed and non-managed services, including non-Medicaid community resources. The SC conducts face to face visits with

the NF member at a minimum of quarterly and more frequently as determined by the member's condition, situation and level of care.

Additionally, the SC coordinate benefits between the Medicare and Medicaid programs to best utilize those benefits in obtaining needed services for the member.

Role of Pharmacy

Pharmacy Provider Responsibilities:

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

Network Limitations

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

Molina Nursing Facility Advisory Committee

Nursing Facility Providers are welcomed to participate in the Molina Nursing Facility Advisory Committee. The Advisory Committee meets every other month, at alternating Molina office locations. The Advisory Committee gives providers an opportunity to share feedback and provide suggestions for areas of improvement. The Committee is open to all nursing facility providers. If you are interested in attending the Committee please email for scheduled dates, times and location: NFProviderServices@Molinahealthcare.com

Chapter 2 – Benefits and Covered Services

STAR+PLUS Medicaid Covered Benefits

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

Nursing Facility Unit Rate

Nursing Facility Unit Rate means the types of services included in the HHSC daily rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services and over-the-counter drugs. The Nursing Facility Unit Rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. Nursing Facility Unit Rate excludes Nursing Facility Add-on Services.

Nursing Facility Add-on Services

Nursing Facility Add-on Services means the types of service that are provided in the Facility setting by the provider or another network provider, but are not included in the NF rate, including but not limited to emergency dental services, physician ordered rehabilitation services; customized power wheelchairs; and augmentative communication devices.

- **Ventilator Care add-on service:** To qualify for supplemental reimbursement, a Nursing Facility Member must require artificial ventilation for at least six consecutive hours daily and the use must be prescribed by a licensed physician.
- **Tracheostomy Care add-on service:** To qualify for supplemental reimbursement, **a Nursing Facility Member must be less than 22 years of age;** require daily cleansing, dressing, and suctioning of a tracheostomy; and be unable to do self-care. The daily care of the tracheostomy must be prescribed by a licensed physician.
- **PT, ST, OT add-on services:** Rehabilitative services are physical therapy, occupational therapy, and speech therapy services (not covered under the NF Unit Rate) for Medicaid nursing facility Members who are not eligible for Medicare or other insurance. The cost of therapy services for Members with Medicare or other insurance coverage or both must be billed to Medicare or other insurance or both. Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and treatment of functions that have been impaired by illness.

Rehabilitative services must be provided with the expectation that the Member's functioning will improve measurably in 30 days.

The provider must ensure that rehabilitative services are provided under a written plan of treatment based on the physician's diagnosis and orders, and that services are documented in the Member's clinical record.

- **Customized Power Wheelchair (CPWC):** To be eligible for a CPWC, a resident must be:
  - Medicaid eligible;
  - age 21 years or older;
  - residing in a licensed and certified Nursing Facility that has a Medicaid contract with the Health and Human Services Commission (HHSC);
  - eligible for and receiving Medicaid services in an Nursing Facility;
  - unable to ambulate independently more than 10 feet;
  - unable to use a manual wheelchair;
  - able to safely operate a power wheelchair;
  - able to use the requested equipment safely in the Nursing Facility;
  - unable to be positioned in a standard power wheelchair;
  - undergoing a mobility status that would be compromised without the requested CPWC; and
  - certified by a signed statement from a physician that the CPWC is medically necessary.

- **Augmentative Communication Device (ACD):** An ACD is a speech-generating device system. A physician and a licensed speech therapist must determine if the ACD is medically necessary.

Note: For Nursing Facility add-on therapy services, Molina will accept claims received from: (1) the Nursing Facility on behalf of employed or contracted therapists; and (2) directly from contracted therapists who are contracted with the MCO. All other Nursing Facility add-on providers must contract directly with and directly bill the MCO.

Nursing facility add-on providers (except Nursing Facility add-on therapy services providers) must refer to the STAR+PLUS Provider Manual for information including credentialing and re-credentialing.

Routine, Urgent and Emergency Services

Definitions

Routine Services means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.

Severely disabled means that the Member's physical condition limits mobility and requires the client to be bed-confined at all times or unable to sit unassisted at all times or requires continuous life-support systems (including oxygen or IV infusion) or monitoring of unusual physical or chemical restraint.

Urgent Services means services for a health condition, including an Urgent Behavioral Health Situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical evaluation or treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within 24 hours but which does not place the Member in immediate danger to themselves or others and the Member is able to cooperate with treatment.

Emergency Behavioral Health Condition- means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine: (1) requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or (2) which renders Members incapable of controlling, knowing or understanding the consequences of their actions.

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

Prescription/Drug Benefits (STAR+PLUS & MMP)

Unlimited medically necessary prescription drugs for STAR+PLUS Medicaid-only members not covered by Medicare. All covered prescriptions are defined by the Vendor Drug Program formulary.

MMP Members and STAR+PLUS Members dually eligible for Medicare will receive most prescription drug services through Medicare rather than Medicaid. The STAR+PLUS Program does cover a limited number of medications not covered by Medicare.

Prescriptions for STAR+PLUS Medicaid-only members that are not on the Vendor Drug Program formulary are the responsibility of the Nursing Facility.

Molina does not limit a Member's ability to obtain medication from any Network pharmacy.

Emergency Pharmacy Services

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

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

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

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information: PA Type 8 PA Auth 801.

Call 1-866-449-6849 for more information about the 72-hour emergency prescription supply policy.

Emergency Transportation

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

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Non-Emergency Transportation

The Nursing Facility is responsible for providing routine non-emergency transportation services. The cost of such transportation is included in the Nursing Facility Unit Rate. Transports of the Nursing Facility Members for rehabilitative treatment (e.g., physical therapy) to outpatient

departments, or to physician's offices for recertification examinations for Nursing Facility care are not reimbursable services by Molina Healthcare.

Molina Healthcare is responsible for authorizing non-emergency ambulance transportation for a Member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation. (i.e., alternate means of transportation are medically contra-indicated.)

Any Member requiring non-emergency ambulance transportation will require a prior authorization of services. The ambulance transportation company must be a Molina Healthcare Network provider. All billing and reimbursement will be directly between the ambulance transportation company and Molina Healthcare.

Medicaid Emergency Dental Services

Molina Healthcare is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for covered emergency dental procedures.

Covered emergency dental procedures include, but are not limited to:

- alleviation of extreme pain in oral cavity associated with serious infection or swelling;
- repair of damage from loss of tooth due to trauma (acute care only, no restoration);
- open or closed reduction of fracture of the maxilla or mandible;
- repair of laceration in or around oral cavity;
- excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
- incision and drainage of cellulitis;
- root canal therapy. Payment is subject to dental necessity review and pre- and post-operative x-rays are required; and
- extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip

Medicaid Non-emergency Dental Services:

Molina Healthcare is **not responsible** for paying for routine dental services provided to Medicaid Members.

Molina Healthcare is **responsible**, however, for paying for treatment and devices for craniofacial anomalies.

Durable Medical Equipment and Other Products Normally Found in Pharmacy

Molina Healthcare reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy and not covered under the nursing facility unit rate. DME covered under the Nursing Facility unit rate includes: medically necessary items such as nebulizers, ostomy supplies or bed pans, and medical accessories (such as cannulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids, IV equipment, and equipment that can be used by more than one person, such as wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars, walkers, and oxygen equipment, such as tanks, concentrators, tubing, masks, valves, and regulators).

Any covered durable medical equipment (DME) will require prior authorization. All billing will be directly between the DME provider and Molina Healthcare.

Behavioral Health

Medicare provides inpatient and outpatient mental health services for MMP enrollees. STAR+PLUS would provide wrap-around coverage for psychiatry and counseling, and substance use treatment services, including outpatient assessment, detoxification and counseling, and residential services. See *Chapter 3 Behavioral Health* for more information.

Nursing Facility STAR+PLUS Value-Added Services (VAS)

STAR+PLUS members who reside in in a Nursing Facility may receive health related items, gift cards for getting various tests and health screenings.

The Nursing Facility STAR+PLUS Value-Added Services also change from time to time. Please visit MolinaHealthcare.com for the most current Value-added services list. Members and Providers can also call Member Services to receive a current and complete list of the Nursing Facility STAR PLUS Value Added Services.

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

The Nursing Facility Service Coordinator may also assist the member in receiving their value-added service.

Medicare-Medicaid Plan (MMP) Benefits

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

Medicare Covered Benefits

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

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

Inpatient and Outpatient Hospital Services (Part A)

Skilled Nursing Facility Services (SNF) (Part A)

MMP Enrollees may receive up to 100 SNF covered days per calendar year

- The 3-midnight hospital stay is waived and does not apply to MMP enrollees
- SNF stays, initial, continued stay, and returning from the hospital require prior authorization dependent upon medical necessity
- Therapy services method of delivery should follow the Medicare guidelines regarding the use of individual, concurrent and group therapy
- Reimbursement of a skilled nursing facility (SNF) stay will be the lesser of billed charges or the Medicare Resource Utilization Group (RUG) at the negotiated contract rate for each RUG:
    - Day 1 – 20: Molina reimburses the lesser of billed charges or the full contracted amount for each Medicare RUG for a SNF stay.
    - Days 21: Molina reimburses at the lesser of billed charges or the contracted amount for each Medicare RUG minus the member's prorated daily applied income as set by the HHSC Medicaid Eligibility Worker.

Physician Visits and Other Acute Services (Part B)

All services and supplies provided under the Medicare Part B program are available to MMP enrollees through the Molina provider network. Services may be provided by the Nursing Facility as is consistent with their licensing and contract.

Some services and supplies require Prior Authorization – please *see Chapter 10 Authorization and Utilization* for more information.

Outpatient Therapy Services

- All outpatient therapy services require prior authorization dependent upon medical necessity

- PT/OT/ST/Audiology services should be delivered following the Medicare guidelines regarding the use of individual, concurrent and group therapy

Other Services/Supplies (Part B)

Services and supplies covered under the traditional Medicare Part B program are covered by MMP. Below are the typical, but not all inclusive, services and supplies that may be utilized in the nursing facility setting. These services and supplies may require Prior Authorization. Please refer to the Prior Authorization chapter for more information.

- Certain Durable Medical Equipment (DME)
- Enteral/Parental Nutrition and supplies
- Urological supplies
- Certain wound care dressings
- Lab services
- X-ray, radiology and imaging
- Prosthetics
- Ambulance transportation
- Physician services

STAR+PLUS Wrap Services (Medicaid)

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

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

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

Behavioral Health (STAR+PLUS & MMP)

Medicare provides inpatient and outpatient mental health services for MMP enrollees. STAR+PLUS would provide wrap-around coverage for psychiatry and counseling, and substance use treatment services, including outpatient assessment, detoxification and counseling, and residential services. *See Chapter 3 Behavioral Health for more information.*

Integrated Services (STAR+PLUS & MMP)

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

MMP covers behavioral health services statewide, including the Dallas SDA.

Medicare-Medicaid Plan (MMP) Flexible Benefits

Flexible Benefits are additional services beyond the services covered by Medicare and Medicaid that promote healthy lifestyles and improve health outcomes among enrollees. Members and Providers can call Member Services to request an updated and complete list of the Molina MMP Flexible Benefits.

Medicare-Medicaid Plan (MMP) Rewards and Incentives

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

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

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

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

The Nursing Facility Service Coordinator may also assist the member in receiving their value-added service.

Nominal Gifts (MMP)

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

Medicaid Program Limitations and Exclusions (STAR+PLUS)

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

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

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

Spell of Illness Limitation STAR+PLUS Only

Effective for dates of admission on or after September 1, 2013, the spell of illness limitation will apply to clients in the STAR+PLUS Program. A spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

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

- A prior-approved solid organ transplant has an additional 30-day spell of illness, which begins on the date of the transplant.

Long Term Services and Supports (LTSS) (STAR+PLUS & MMP)

Money Follows the Person (MFP)

Nursing Facility Members may be eligible for the HHSC Money Follows the Person waiver program which allows certain Texans who are eligible for Medicaid and living in a nursing facility to choose an appropriate community setting and receive community services and supports.

Goals of MFP:

- To permit members to reside safely in the least restrictive environment
- To ensure the member has access to those services necessary to keep them safe in the community
- To prevent, delay or reduce the need for costly institutional LTC services
- To engage the member and involved other in a person-centered plan

Eligibility for MFP:

- Be Medicaid eligible
- Reside continuously in a Medicaid certified nursing facility for at least 90 days
- Express a desire to reside in the community
- Receive a waiver approval from HHSC through the application process

Services and Supports under MFP:

- Personal Assistant Services (PAS): provides in-home assistance to individuals as identified and authorized on his/her individual service plan with the performance of activities of daily living, household chores, and nursing tasks that have been delegated by a registered nurse (RN).
- Day Activity and Health Services (DAHS): include nursing and personal care services, physical rehabilitative services, nutrition services, transportation services, and other supportive

services as identified and authorized on his/ her individual service plan. These services are given by facilities licensed by HHSC.

Referral to MFP:

NF Members expressing the desire to move out of the NF should be referred to the assigned NF Service Coordinator to initiate the MFP assessment process.

Referrals to the MFP program may come from:

- The nursing home resident
- The resident's guardian
- The resident's family
- The Power of Attorney
- The nursing facility – possibly identified through the MDS process or by individual making their desires known verbally to NF Staff
- The Relocation Specialist
- The Ombudsman
- HHSC (as identified in the MDS)
- The MCO Service Coordinator – as identified in the MDS or via conversation with the member

A referral does not mean the member will qualify for MFP or move out of the facility, but it starts the assessment process

Leaving NF without going through the MFP program:

If NF Members who has resided in the NF for 90 days or more leaves the NF to go back to the community without going through the MFP program, they have the potential to lose their Medicaid eligibility and may be placed on a waiting list for services.

Chapter 3 – Service Coordination

Service Coordination for NF Members and MMP Enrollees

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

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

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

All Care coordinator staff members can assist with basic inquires. If additional follow up is needed, the assigned Service Coordinator will contact the provider or member within 24 hours. To contact Molina's care coordinator team call 1-866-409-0039.

<u>The Service Coordinator will be responsible for:</u>

- Coordinating services when a member transitions into a Nursing Facility
- Partnering with the member, family, NF Care Coordinator/staff and others in the development of a service plan, including services provided through the NF, add-on services, acute medical services, behavioral health service and primary or specialty care. The approval of additional services outside of the NF daily unit rate is based on medical necessity and benefit structure.
- Participating in Nursing Facility care planning meetings telephonically or in person, provided the member does not object.
- Comprehensively reviewing the member's service plan, including the Nursing Facility plan of care, at least annually, or when there is a significant change in condition.
- Evaluating members living in nursing facilities at least quarterly. Visit to include, at minimum, a review of the member's service plan, clinical record and when possible, a person-centered discussion with the member about the services and supports the member is receiving, any unmet needs or gaps in the person's service plan, and any other aspect of the member's life or situation that may need to be addressed. Additionally, during the visit the SC will interact with nursing facility staff as needed to assure the resident's needs and concerns are being addressed.
- Assisting with the collection of applied income when a NF has documented unsuccessful efforts, per HHSC-mandated NF requirements. The SC will reach out to the responsible

party who controls the funds and explain the importance of paying the applied income, as it could put the resident at risk of being discharged and/or being relocated for non-payment to the NF.

- Cooperating with representatives of regulatory and investigating entities including HHSC Regulatory Services, the LTC Ombudsman Program, HHSC trust fund monitors, Adult Protective Services, the Office of the Inspector General, and law enforcement.
- Fulfilling requirements of the Texas Promoting Independence Initiative (PII) as described in the UMCC Section 8.3.9.2. The quarterly in-person visits required of the Service Coordinator can include assessments required under PII, and the Service Coordinator can serve as the point of contact for an individual referred to return to the community under PII. *See Chapter 2 Benefits and Services – Money Follows the Person*
- Coordinating with the NF discharge planning staff to discharge and transition from the NF. Transitional Assistance Services (TAS): assists individuals who are nursing facility residents to discharge to the community and set up household. A maximum of $2500 is available on a one-time basis to help defray the costs associated with setting up a household. TAS include, but are not limited to, payment of security deposits to lease an apartment, purchase of essential furnishings (table, eating utensils), payment of moving expenses, etc.
- Notifying the NF within 10 ten days of a change in the Service Coordinator
- Returning a call from the NF within 24 hours after the call is placed by the NF.

<u>The Nursing Facility Staff are responsible for:</u>

- Inviting the Service Coordinator to provide input for the development of the NF care plan, subject to the member's right to refuse, by notifying the SC when the interdisciplinary team is scheduled to meet. NF care planning meetings should not be contingent on the SC participation
- Notifying the SC within one business day of unplanned admission or discharge to a hospital or other acute facility, skilled bed, long term care services and supports provider, non-contracted bed, another nursing or long-term care facility. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Notifying the SC if a member is admitted into hospice care
- Notifying within one business day of an adverse change in a member's physical or mental condition or environment that could potentially lead to hospitalization or emergency department visit. Additionally, the SC should be notified of the development of a wound (decubitus, etc.) Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Coordinating with the SC to plan discharge and transition from the Nursing Facility
- Notifying the SC within one business day of an emergency room visit. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Notifying the SC within 72 hours of a member's death. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.

- Notifying the SC of any other important circumstances such as relocation of residents due to a natural disaster, fire, or other event that would require relocation. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Notifying the SC if the facility initiates an involuntary discharge of a member, including involuntary discharge for non-payment of charges, clinical needs, clinical compliance or behavioral issues.
- Providing the SC access to the facility, Nursing Facility staff and the member's medical information and records.

Coordination with Providers of Non-Capitated Services

Molina Healthcare will assist members with accessing programs such as the Texas agency administered programs and case management services, and essential public health services. These non-capitated services are not included in the NF Unit Rate nor are they part of the Nursing Facility Add-On services. The Texas Medicaid Provider Procedures Manual includes a complete list of carve-out services for STAR+PLUS.

The Service Coordinator will work with NF staff to refer members to obtain services as described in the Texas Medicaid Provider Procedures Manual (TMPPM) including the following services:

- Effective January 1, 2017, Northstar will be discontinued and MCOs in the Dallas Service Area will be responsible for Medicaid Behavioral Health Services and MMP Behavioral Health Services consistent with all over Service Areas. *(See Chapter 4 Behavioral Health Services for more information)*
- Providers must coordinate with the local tuberculosis control program to ensure that all Members with confirmed or suspected tuberculosis have a contact investigation and receive directly observed therapy by a DSHS-approved provider. The Provider must report to DSHS or the local Tuberculosis control program any Member who is non-compliant, drug resistant, or who is or may be posing a public threat.
- Hospices services provided by Home and Community Support Service Agencies contracted with the Department of Aging and Disability Services.
- Preadmission Screening and Resident Review (PASRR) Level 1 screenings, Level 2 evaluations, and specialized services provided by HHSC-contracted local authority (LA) and DSHS-contracted local mental health authority (LMHA). Specialized services provided by the LA include: service coordination, alternate placement, and vocational training. Specialized services provided by the LMHA include mental health rehabilitative serviced and targeted case management. Specialized serviced provided by a NF for individuals identified as IDD include physical therapy, occupational therapy, speech therapy and customized adaptive aids. All PASRR specialized services are non-capitated, fee-for-service.
- Long Term Care services and supports for individuals who have intellectual or developmental disabilities provided by HHSC contracted providers.

Chapter 4 – Behavioral Health Services

Behavioral Health

Molina Healthcare recognizes that the access to high quality behavioral healthcare is critical to the overall health and well-being of their members.

What is Behavioral Health?

Behavioral health services are provided for the treatment of mental disorders, emotional disorders, and chemical dependency disorders. Molina offers a behavioral health program that integrates management of behavioral health care with medical care needs for children and adults.

Molina behavioral health services are offered through a large and comprehensive network of Behavioral Health (BH) providers located within each service area. In order to better assist these valued BH providers Molina Healthcare now manages behavioral health services with a Behavioral Health Care Management Team. This team is comprised of licensed behavioral health professionals who will assist the behavioral health provider network, as well as medical care providers and other community support programs to communicate, coordinate and meet the integrated care needs of our members.

Call Molina at (866) 449-6849 for behavioral health questions. Members can also call the 24-hour Behavioral Health Crisis Line at (800) 818-5837 in crisis situations. This number is on the back of member ID cards.

Behavioral Health Care Management Team

The Molina Healthcare Behavioral Health Care Management Team provides co-location of licensed behavioral health professionals with the medical care management, care coordination and general utilization management teams. This cross-disciplinary team consists of dedicated professionals (e.g., psychiatrists, nurse practitioners, clinical social workers, licensed professional counselors) who are on hand to work in collaboration with the medical care managers to assist with appropriate coordination between behavioral health and physical health services.

Behavioral Health Services Hotline

Molina Healthcare maintains a 24 hour/7 days a week toll-free Behavioral Health Crisis Hotline; Crisis line services are provided during normal business hours, as well as after business hours, by the Molina Healthcare.

English: (800) 818-5837 (Translation services available)

Nurse Advice Line (NAL)

Molina Healthcare has a toll-free multi-lingual nurse advice telephone line available to Members and Providers on a 24-hour basis, 7 days per week. Staff on this advice line take calls from Members and perform triage services to help determine the appropriate setting from which they should obtain necessary care. In all instances, the staff on the advice line coordinates all care with the Member's primary care physician.

The nurse advice line is accessed through a toll-free telephone number, as well as through information in the Member handbook and other written material. The Nurse Advice Line phone numbers are:

English: 1-888-AskUs50 1-888-275-8750
Spanish: 1-866-Mi TeleSalud 1-866-648-3537

Coordination, Self-Referral, PCP Referral

The member may self-refer for behavioral health services to any in-network Behavioral Health provider. However, Primary Care Providers participating in the Texas Medicaid STAR+PLUS are responsible for coordinating Members' physical and behavioral health care, including making referrals to BH providers when necessary. PCPs may provide any clinically appropriate behavioral health services within the scope of their practice.

Behavioral health service providers must refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or member's legal guardian's or member's Durable Medical Power of Attorney's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. Behavioral health providers must send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PCP, with the member's or member's legal guardian's consent.

The Molina Healthcare Behavioral Healthcare Management Team will assist in the cross communication of patient information, referral needs, treatment progress, etc. between Behavioral Health providers and the PCP. You can call them at 1-800-818-5837.

Member Access to Behavioral Health Services

Members may access services with any participating provider within the Molina Healthcare behavioral health care network by contacting the Molina BH team at 1-800-818-5837 or by contacting Molina Member Services at 1-866-449-6849. Case Managers are available to answer

questions regarding treatment options, medications, and behavioral health issues twenty-four (24) hours per day, seven (7) days per week.

Covered Behavioral Health Services

A wide range of behavioral health and chemical dependency services are available although specific benefits and benefit limits vary according to coverage group and member age (e.g., CHIP, CHIP Perinate, STAR or STAR+PLUS). Generally, the following services may be available:

- Inpatient and Outpatient behavioral health services
- Outpatient chemical dependency services
- Detoxification services
- Psychiatry services

Court Ordered Commitments

Up to the annual limit, Molina will provide inpatient psychiatric services to Members who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities. Molina will not deny, reduce or controvert the medical necessity of any inpatient psychiatric services provided pursuant to a court-ordered commitment. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Member who has been ordered to receive treatment under the provisions of Chapters 573 or 574 of the Texas Health and Safety Code can only appeal the commitment through the court system and cannot appeal the commitment through Molina's complaint and appeals process. Molina is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code.

$200,000 annual limit on inpatient services does not apply for Star + Plus members.

Coordination with the Local Mental Health Authority

Molina will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning and treatment objectives, and projected length of stay for members committed by a court of law to the state psychiatric facility.

Medical Records and Referral Documentation

When reporting to HHSC, Behavioral Health providers must use the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification in effect at the time of service. For Medicaid members, HHSC requires the use of other assessment instruments/outcomes measures in addition to the DSM.

Providers must document DSM diagnoses and any assessment or outcome information in the Member's medical record.

The Member's medical record must document dates of follow-up or next appointments as well as any discharge plans. Post-discharge appointments are to occur within 7 days of discharge.

Consent for Disclosure of Information

Providers are required to obtain consent for the disclosure of information from the Member permitting the exchange of clinical information between the behavioral health provider and the Member's physical health provider.

Focus Studies

Molina Healthcare conducts annual focus studies on the coordination of care and continuity of services for both behavioral and medical providers. Members are encouraged to actively participate in the selection of their BH practitioner and may speak with a Molina Healthcare clinical representative at any time to coordinate their behavioral care. Molina also runs annual focus studies to insure member satisfaction with the services delivered through the Behavioral Health Hotline.

Utilization Management Reporting Requirements

Molina addresses utilization management requirements through the use of an annual chart audit review to insure provision of services by behavioral health providers is in accordance with both state and federal regulations. The chart audits may include but are not limited to treatment plan reviews, assessment of services delivered by licensed clinical staff, a listed complete DSM diagnosis and adherence to PHI standards.

Chapter 5 – Provider Responsibilities

Nursing Facility Care and Services

The Nursing Facility is responsible to coordinate all care and services with the Primary Care Provider (Nursing Facility Attending physician) to assure member needs are addressed.

The Nursing Facility must provide 24-hour nursing facility covered services included in the Nursing Facility Unit Rate such as semi-private room and board, regular nursing services, medical supplies and equipment, personal need items, social services and over the counter drugs.

Additionally, the Nursing Facility will coordinate for the member access to Nursing Facility Add-On Services including but not limited to emergency dental services, physician ordered rehabilitation services; customized power wheelchairs; and augmentative communication devices.

Provider understands and agrees that:

1. It will comply with all state and federal Regulatory Requirements governing nursing facilities, including as applicable:
    a. Title 42 C.F.R., Chapter IV;
    b. Texas Human Resources Code Chapter 32;
    c. Texas Human Resources Code Chapter 102;
    d. Texas Health and Safety Code Chapters 242, 250, 253, and 260; and
    e. Title 40, TAC Chapter 19.
2. It is currently, and for the term of the Agreement will remain, a Texas Medicaid participating provider under applicable state and federal Regulatory Requirements.
3. All employees, agents, and subcontractors will perform their duties in accordance with the above-referenced licensure and Regulatory Requirements, as well as all applicable national, state and local standards of professional ethics and practice.

Updates to Information

The Provider must notify Molina and HHSC of any changes to information including:

- Name
- Address
- Telephone number
- Billing/Payment remittance address
- Tax Identification Number (TIN)
- Change of Ownership
- National Provider Identifier (NPI)

- HHSC License Number
- Direct Care Staff Rate Enhancement Level
- General Liability Insurance status
- Professional Liability Insurance status

The form in Appendix A of the Contract may be used to communicate such changes of information and sent to:

Molina Healthcare of Texas
1660 N. Westridge Circle
Irving, Texas 75038
FAX 972-756-9275
Attn: Provider Credentialing

Access to Records and Information

The Provider will provide Molina representatives access to the facility for the purposes of service coordination; member services activities and general provider services activities. Hours of access will be reasonable and not interfere with the provision of patient care by the Provider. The Provider will provide reasonable notice of and opportunity to participate in care planning discussions and activities.

The Provider must provide reasonable access to the Members' medical records and allow access to the Facility and other premises where records are kept. Access includes the ability to view electronic health records as well as traditional paper records.

The Provider must comply with timelines, definitions, formats and instructions specified by HHSC.

Upon the receipt of record review request from HHSC, OIG or another state or federal agency authorized to conduct compliance, regulatory or program integrity functions, the Provide must provide, at no cost to the requesting agency, the records requested within three business days. If the HHSC, OIG or another state or federal agency representatives reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request or in less than 24 hours, the Provider must provide records requested at that time of the request or in less than 24 hours. The request for record review may include:

- Members' clinical records
- Other records pertaining to the Member;
- Any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services;
- Documents related to diagnosis, treatment, service, lab results, charting
- Billing records, invoices, documentation of delivery items, equipment or supplies;

- Business and accounting records or reports with backup support documentation;
- Financial audits
- Statistical documentation;
- Computer records and data; and
- Contracts with providers and subcontractors.

Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in the HHSC, OIG imposing sanctions against the provider as described in 1 TAC, Chapter 371, Subchapter G

Plan Termination

Molina Healthcare is committed to maintaining a network of Nursing Facility providers to meet the needs of the Members. If termination is being considered the following requirements must be met:

- Mutual Agreement to Terminate - by Molina Healthcare and the Nursing Facility. The agreement must be in writing with agreed upon time frames to assure continuity of services for the members.
- Termination for Cause – defined as a material breach by the other party. The notice must provide 90 days' notice and will set forth the reasons for the termination. It will also provide the breaching party 90 days to cure the material breach or the termination becomes effective.
- The MCO must follow procedures outlined in 843.306 of the Texas Insurance Code if terminating the agreement. At least 90 days before the effective date the proposed termination of the agreement, the MCS must provide a written explanation to the Provider for the reasons for termination. The MCO may immediately terminate the agreement in a case involving:
    - Imminent harm to patient health;
    - An action by a state licensing board or government agency against the Nursing Facility, or an action by a State Medical Board against the Provider's Medical Director, that effectively impairs the Provider's ability to provide services; or
    - Fraud or malfeasance
- No later than 30 days following the receipt of the termination notice, the Provider may request a review of Molina Healthcare's proposed termination by an advisory review panel, except in which there is imminent harm to patient health, an action against a license, or Fraud or malfeasance. The advisory review panel must be composed of physicians and providers, as those terms are defined in 843.306 of the Texas Insurance Code, including at least one representative in the provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of Molina Healthcare. Molina Healthcare must consider the advisory review panel's decision but is not binding on Molina Healthcare. Within 60 days following the receipt of the provider's request for review and before the effective date of the termination, the advisory review panel must make its formal

recommendation, and Molina Healthcare must communicate its decision to the provider. Molina Healthcare must provide the affected providers, on request, a copy of the recommendation of the advisory review panel and Molina Healthcare's determination.

- If the Provider is terminated, barred, suspended or otherwise excluded from participation in, or has voluntarily withdrawn as the result of a settlement agreement related to, any program under Titles XVII, XIX, XX or XXI of the Social Security Act, the Agreement will automatically and immediately terminate.
- The Provider may not offer or give anything of value to an officer or employee of HHSC or the State of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and federal law. Molina Healthcare may terminate the agreement at any time for violation of this requirement.
- If a termination does occur, the Molina Service Coordinator will offer members relocation to another network nursing facility, based upon resident needs and preferences. The Service Coordinator will work with the Nursing Facility staff to assure a smooth transition for the member.
- Members who do not choose to relocate to another Molina Network nursing facility will continue to receive services in their existing nursing facility, as well as Service Coordination from Molina Healthcare Services department.
- The Nursing Facility will continue to bill and receive payment for Molina members after termination date for those Members who do not relocate to a Molina Network nursing facility but will be paid at 95% of existing Nursing Facility Unit Rate and Add-On Services rates. The Nursing Facility will no longer have the benefits of an agreement, therefore will be subject to standard claims processing and payment procedures.

Nursing Facility Service Coordination Responsibilities

<u>The Nursing Facility Staff are responsible for:</u>

- Inviting the Service Coordinator to provide input for the development of the NF care plan, subject to the member's right to refuse, by notifying the SC when the interdisciplinary team is scheduled to meet. NF care planning meetings should not be contingent on the SC participation
- Notifying the SC within one business day of unplanned admission or discharge to a hospital or other acute facility, skilled bed, long term care services and supports provider, non-contracted bed, another nursing or long-term care facility. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Notifying the SC if a member is admitted into hospice care

- Notifying within one business day of an adverse change in a member's physical or mental condition or environment that could potentially lead to hospitalization or emergency department visit. Additionally, the SC should be notified of the development of a wound (decubitus, etc.) Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Coordinating with the SC to plan discharge and transition from the Nursing Facility
- Notifying the SC within one business day of an emergency room visit. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Notifying the SC within 72 hours of a member's death. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Notifying the SC of any other important circumstances such as relocation of residents due to a natural disaster, fire, or other event that would require relocation. Notification may be by telephone, secure email or by fax to the numbers provided by the Service Coordinator.
- Notifying the SC if the facility initiates an involuntary discharge of a member, including involuntary discharge for non-payment of charges, clinical needs, clinical compliance or behavioral issues.
- Providing the SC access to the facility, Nursing Facility staff and the member's medical information and records.

HHSC Form 3618

The Nursing Facility Provider must complete and submit Form 3618 to HHSC's administrative services contractor.

Purpose

- To inform Texas Health and Human Services Commission (HHSC) staff about transactions and status changes for Medicaid applicants and recipients.
- To provide HHSC state office with information necessary to initiate, close or adjust vendor payments. These payments are made on behalf of eligible recipients in contracted Title XIX facilities.
- To provide data necessary for statistical reports.

Procedure

Form 3618, Resident Transaction Notice, can only be submitted electronically by completing Form 3618 on the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Portal.

Electronic submission is prescribed by the Texas Administrative Code, 40 TAC §19.2615, which states:

- A nursing facility must electronically submit to HHSC's Medicaid claims administrator a resident transaction notice within 72 hours after a recipient's admission or discharge from the Medicaid nursing facility vendor payment system. The nursing facility administrator must sign the resident transaction notice.
- The nursing facility must print out and complete all items on Form 3618, including Item 13 with the nursing facility administrator's State Board license number, and have the nursing facility administrator sign and date Form 3618 for Item 14.

When to Prepare

The nursing facility administrator prepares Form 3618 for recipients who are:

- eligible Medicaid recipients,
- applicants for medical assistance, or
- Medicaid recipients who are being discharged from the Medicaid program.

The nursing facility administrator prepares a separate Form 3618 for each transaction. Each admission into or discharge from the facility requires a Form 3618 except approved therapeutic passes. An admission or discharge between payor sources also requires Form 3618 or Form 3619, Medicare/Skilled Nursing Facility Patient Transaction Notice. Example: Form 3619 discharge from Medicare and Form 3618 admission to Medicare to change payor source from Medicare to Medicaid.

Form 3618 must be completed, and all copies submitted within 72 hours of the date of the transaction.

Form 3618 is not used to report transactions involving private-pay residents, except when a resident who has been private pay is applying for Medicaid or when a recipient has been receiving Medicaid and is denied.

HHSC Form 3619

The Nursing Facility Provider must complete and submit Form 3619 to HHSC's administrative services contractor.

Purpose

- To inform Texas Health and Human Services Commission (HHSC) staff about transactions and status changes for Medicaid applicants and recipients.
- To provide HHSC state office with information necessary to initiate, close or adjust Medicare skilled coinsurance payments. These payments are made on behalf of eligible recipients in Medicare skilled nursing facilities.
- To provide data necessary for statistical reports.

Procedure

Form 3619, Medicare/Skilled Nursing Facility Patient Transaction Notice, can only be submitted electronically by completing Form 3619 on the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Portal.

Electronic submission is prescribed by the Texas Administrative Code, 40 TAC §19.2615, which states:

- A nursing facility must electronically submit to HHSC's Medicaid claims administrator a resident transaction notice within 72 hours after a recipient's admission or discharge from the Medicaid nursing facility vendor payment system. The nursing facility administrator must sign the resident transaction notice
- The nursing facility must print out and complete all items on Form 3619 including Item 14 with the nursing facility administrator's State Board license number and have the nursing facility administrator sign and date Form 3619 for Item 15.

When to Prepare

The nursing facility administrator prepares Form 3619 for recipients who are Medicaid recipients/applicants approved by Medicare for a Medicare skilled nursing facility (SNF) stay.

The nursing facility administrator prepares a separate Form 3619 for each transaction. Each admission into or discharge from the facility requires a Form 3619 except approved therapeutic passes. An admission or discharge between payor sources also requires Form 3618, Resident Transaction Notice, and Form 3619, Patient Transaction Notice. Example: Form 3619 discharge from Medicare and Form 3618 admission to Medicare to change payor source from Medicare to Medicaid.

Form 3619 must be completed, and all copies submitted within 72 hours of the date of the transaction.

Form 3619 is not used to report transactions involving private-pay residents.

Access HSSC Forms and Instructions for complete submission instructions regarding Forms 3618 and 3619.

Minimum Data Set (MDS)

The Centers for Medicare and Medicaid Services (CMS) requires certified nursing facilities to complete and transmit Minimum Data Set (MDS) assessments for all nursing facility residents. Reference the Code of Federal Regulations (CFR), Title 42, Chapter IV, Part 483.20.
The state of Texas requires nursing facilities to complete and transmit MDS assessments to HHSC administrative services contractor for all residents, including private pay residents.

Reference the Texas Administrative Code - Nursing Facility Requirements for Licensure and Medicaid Certification, Title 40, Part 1, Chapter 19, Subchapter I, Section 19.801.

According to state code, all MDS assessments and tracking forms are transmitted to the MDS central repository following the schedule, format and procedures documented in the CMS Long Term Care Resident Assessment Instrument (RAI) User's Manual. Reference the MDS 2.0 RAI Manual, effective December 2002, or the MDS 3.0 RAI Manual, effective Oct. 1, 2010. Or per any update of the RAI Manual.

Long Term Care Medical Information (LTCMI)

Providers must utilize the TMHP LTC Online Portal to complete the LTCMI **i**n order for a Minimum Data Set (MDS) assessment to be used for State Medicaid payment, it must be submitted to the HHSC Database, and successfully extracted by the Texas Medicaid & Healthcare Partnership (TMHP) onto the Long-Term Care (LTC) Online Portal. According to the Texas Administrative Rule §19.2413(b)(2), the provider must complete the LTCMI section and submit for processing. This has been the case since September 2008 and applies to MDS Modifications as well as original submissions. An MDS assessment is not considered complete and cannot be used for State Medicaid payment until the LTCMI section is successfully submitted on the LTC Online Portal.

Access TMHP Forms and Instructions for complete submission instructions regarding LTCMI forms: ***http://www.tmhp.com/Pages/LTC/ltc_forms.aspx***

Reporting Abuse, Neglect or Exploitation

- Providers are required to report Abuse, Neglect and Exploitation as defined by HHSC.
- Providers are required to inform members on how to report Abuse, Neglect and Exploitation as defined by HHSC.
- Providers are required to training staff on how to recognize and report Abuse, Neglect and Exploitation as defined by HHSC.

Please see ***Chapter 6 Abuse, Neglect and Exploitation*** for more information.

Preadmission Screening and Resident Review (PASRR)

All individuals seeking entry into a nursing facility must have PASRR Level 1 (PL1) screening before admission.

Preadmission Screening and Resident Review (PASRR) is a federally mandated program that is applied to all individuals seeking admission to a Medicaid-certified nursing facility, regardless of funding source.

PASRR must be administered to identify:

- individuals who have a mental illness, an intellectual disability or a developmental disability (also known as related conditions),
- the appropriateness of placement in the nursing facility, and
- the eligibility for specialized services.

The PASRR Level 1 (PL1) is completed for every individual seeking admission to a Medicaid certified nursing facility regardless of their funding source or diagnosis. The form must be completed and submitted to HHSC's administrative services contractor. Directions for completion and submission of the PL1 can be found at: *http://www.tmhp.com/Pages/LTC/ltc_forms.aspx*

- If the **screening is positive** — meaning the individual is suspected of having a mental illness, an intellectual disability or a developmental disability — the LA will complete and submit a PASRR Level 2 Evaluation form PE within seven to 14 days, depending on the type of admission and length of stay.
- If the **screening is negative** — meaning the individual is not suspected of having a mental illness, an intellectual disability or a developmental disability — the nursing facility enters the PL1 into the Texas Medicaid Healthcare Partnership Long-term Care (LTC) Online portal, and the PASRR process ends for that individual.

Interdisciplinary Team (IDT) Meeting and Certification Process

NFs are required to take two steps to complete the PASRR Admission Process:

1. Certify the ability to meet the individual's needs by answering two questions/fields in Section D of the PL1:
    - Field D0100N. NF is willing and able to serve individual
    - Field D0100O. NF Admitted the individual (only the admitting NF should Complete this field)
2. Invite the Local Authority/Local Mental Health Authority (LA/LMHA) to participate in the IDT/Care Planning Meeting by informing the LA/LMHA of the date and time of the meeting. This meeting must occur within the first 14 days of admission.

The LA/LMHA must participate in the IDT/Care Planning Meeting for all newly admitted PASRR positive individuals regardless of service array. The LA/LMHA does not have to be physically present at the meeting; participation by telephone is permissible. The LA/LMHA specialized services should be included in the NF's Comprehensive Care Plan. All finalized specialized services must be initiated for delivery within 30 days after the specialized services are identified in the Comprehensive Care Plan.

The NF is responsible for initiating and/or providing physical therapy, occupational therapy, and speech therapy.

The LA/LMHA is responsible for initiating and/or providing service coordination, alternate placement, and vocational rehabilitation (where available).

Specialty Care Provider Responsibilities

Some specialty services require a referral from the PCP. The Specialist may order diagnostic tests without PCP involvement; however, the Specialist may not refer to another specialist except in a true emergency situation. Specialists must abide by the referral and authorization guidelines as described in "What Requires Authorization."

The Specialist provider must:

- Verify eligibility,
- Obtain referral or authorization from the PCP before providing certain services,
- Refer the member to another specialist provider,
- Provide the PCP with consultation reports and other appropriate records in a timely manner,
- Participate in Peer Review Process and be available for or provide on call coverage through another source 24 hours a day.
- Maintain regular hours of operation that are clearly defined and communicated to members, and
- Provide urgent specialty care within 24 hours of request.

Continuity of Care

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

- exhibit pre-existing conditions
- In the 24th week of pregnancy (STAR only)
- Receiving care for an acute medical condition
- Receiving care for an acute episode of a chronic condition
- Receiving care for a life-threatening illness, and
- Receiving care for a disability
- Currently hospitalized
- Transferring between facilities

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

What if a member moves?

If a member moves out of the Molina Service Deliver Area, Molina will continue to cover medically necessary care through network and non-network providers until such time as the member can be transitioned to a MCO providing services in the new area.

Request to Discharge a Member

It may become necessary for a PCP to discharge a member from his/her panel. Prior to discharging a member, the primary care physician must counsel the patient regarding the patient/physician relationship. Such counseling must be documented appropriately in the medical chart, an incident report or treatment plan. If the behavior does not improve, the PCP may request in writing to the Plan, the member be dismissed from his/her panel. The Member Services department will send written notification to the member advising them to select a new PCP. The PCP is required to continue treating the member for 30 days following the notification to the member to make the transition.

Appointment Availability/Waiting Times for Appointments

The following schedule should be followed by all Molina network providers regarding appointment availability:

- Routine exams should be provided within 14 days of request.
- Preventive health services for adults within 90 days
- Urgent care should be received within 24 hours of the request.
- Emergency care should be received immediately.
- Referrals to a specialist should be seen within 30 days of a request.
- Prenatal Care in 3rd Trimester to an OB/GYN should be seen within 5 days of a request.
- New Member 90 days from a request.
- Prenatal 14 days Unless high risk

Role/Responsibility of the Primary Care Provider

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

- Be available for or provide on call coverage through another source 24 hours a day.

- Maintain regular hours of operation that are clearly defined and communicated to members
- Refer the member to specialist provider as needed
- Maintain clinical documentation
- The PCP may provide behavioral health-related services within their scope of practice

Referrals to Network Facilities and Contractors

Referrals to network facilities and contractors do not require a prior authorization except as specifically noted on the current Prior Authorization Guide. See *Chapter 10 Authorization and Utilization*.

Second Opinions

Members or Member's PCP can request a second opinion on behalf of the Member. If you or a Member request a second opinion, Molina will give you a decision within 48 hours. If it is an imminent and serious threat, Molina will respond within one (1) day and the second opinion will be given within seventy-two (72) hours. If a qualified Participating Provider is not available to give the Member a second opinion, Molina will make arrangements for a Non-Participating Provider to give them a second opinion. If Molina denies the second opinion because it is not medically necessary, we will send the Member a letter. Members or Providers may appeal the decision. The letter from Molina will tell you how to appeal.

Referral to Specialists

The PCP must assess the medical needs of Members and make medically necessary referrals to specialty care providers who are currently enrolled as participating provider with Molina Healthcare. If PCP believes that a Member needs to be referred to an Out-of Network provider, including medical partners not contracted with Molina, documentation demonstrating the need must be submitted to Molina Healthcare for review and prior authorization before referral can occur.

Members with disabilities, special health care needs, or chronic or complex conditions are allowed direct access to a specialist.

Coordination and Referral to Other Health and Community Resources

The PCP must coordinate the care of Members with other Medicaid programs, public health agencies and community resources which provide medical, nutritional, educational, and outreach services to Members, including Women, Infants and Children Program (WIC), school health clinics, and local health and mental health departments.

Advance Directives - Medical Power of Attorney – OOH-DNR

An advance directive is a formal document, written in advance of an incapacitating illness or injury, in which one can assign decision-making for future medical needs and treatments. A Medical Power of Attorney is a document signed by a competent adult, designating someone that the person trusts to make health care decisions on that person's behalf should that individual be unable to make such decisions. Any provider delivering care to a Molina Member must ensure Members receive information on Advance Directives and Medical Power of Attorney and are informed of their right to execute Advance Directives and Medical Power of Attorney. Providers must document such information on the permanent medical record.

Out of Hospital Do-Not-Resuscitate Order

The OOH-DNR is for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provisions of other emergency care, including comfort care. Any provider delivering care to a Molina Member must ensure Members receive information on OOH-DNR and are informed of their right to execute an OOH-DNR. Providers must document such information on the permanent medical record.

Medical Records

Providers must maintain confidential and complete medical records. Records must reflect all aspects of patient care, including ancillary services. Such records will enable providers to render the highest quality health care and enable Molina to review the quality and appropriateness of services. The use of electronic medical records must conform to the requirements of the Health Insurance Protability and Accountability Act (HIPAA) and other federal and state laws.

<u>Medical Record Keeping Practices</u>

The following record keeping practices must be followed:

- Each patient has a separate medical record and pages are securely attached in the medical record.
- Medical records are organized with dividers.
- A chronic problem list is included in the record for all adults and children.
- Records are available at each encounter or are traceable.
- A complete health history is part of the record.
- Health maintenance forms include dates of preventive services.
- Medication sheets are complete and sample medications are documented.
- A system is in place to document missed appointments and phone messages.
- Advance Directives are discussed and documented for those over 18 years of age.
- Medical record retention is sufficient (at least 6 years).

Medical Record Documentation

A confidential medical record must be maintained for each Member that includes all pertinent information regarding medical services rendered. Providers must maintain established standards for accurate medical record keeping. Six categories have been designated as critical areas. These areas are:

- Problem lists
- Allergy designation
- Past medical history
- Working diagnosis consistent with findings
- Plans of action/treatment consistent with diagnosis
- Care medically appropriate

Providers must demonstrate 85% overall compliance in medical record documentation and 85% in each of the six critical categories. Molina uses the guidelines below when evaluating medical record documentation.

- A completed problem list is in a prominent space. Any absence of chronic/significant problems must be noted.
- Allergies are listed on the front cover of the record or prominently in the inside front page. If the patient has no known allergies, this is appropriately noted.
- A complete medical history is easily identified for patients seen three or more times. A working diagnosis is recorded with the clinical findings. Subjective, Objective, Assessment and Plan (SOAP) charting is recommended but not mandatory when progress notes are written.
- The plan of action and treatment is documented for the diagnosis.
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Patient name and identifying number is on each page of the record.
- The registration form or computer printout contains address, home, and work phone numbers, employer, gender and marital status. An emergency contact should also be designated.
- All staff and Provider notes are signed with initials or first initial, last name and title.
- All entries are dated.
- The record is legible to someone in the office other than the Provider. - Dictation is preferred.
- There is an appropriate notation concerning the use of alcohol, tobacco, and substance abuse for patients 12 years old and older. - query history of the abuse by the time the patient has been seen three or more times.
- Pertinent history for presenting problem is included.
- Record of pertinent physical exam for the presenting problem is included.
- Lab and other studies are ordered as appropriate.
- There are notations regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed. Include the preventive care visit when appropriate.

- Previous unresolved problems are addressed in subsequent visits.
- Evidence of appropriate use of consultants. This is reviewed for under and over utilization.
- Notes from consultants are in the record.
- All reports show initials of practitioner who ordered them.
- All consult and abnormal lab/imaging results show explicit follow-up plans.
- There is documentation of appropriate health promotion and disease prevention education. Anticipatory guidance is documented at each well child check.
- An immunization record and appropriate history of immunizations have been made for adults.
- Preventive services are appropriately used/offered in accordance with accepted practice guidelines.

Medical Record Confidentiality

Molina Members have the right to full consideration of their privacy concerning their medical care. They are also entitled to confidential treatment of all Member communications and records. Case discussion, consultation, examination, and treatments are confidential and should be conducted with discretion. Written authorization from the Member or his/her authorized legal representative must be obtained before medical records are released to anyone not directly connected with his/her care, except as permitted or required by law.

Confidential Information is defined as any form of data, including but not limited to, data that can directly or indirectly identify individual Members by character, conduct, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. Conversations, whether in a formal or informal setting, e-mail, faxes and letters are also potential sources of Confidential Information.

All participating Providers must implement and maintain an office procedure that will guard against disclosure of any Confidential Information to unauthorized persons. This procedure should include:

- Written authorization obtained from the Member or his/her legal representative before medical records are made available to anyone not directly connected with his/her care, except as permitted or required by law.
- All signed authorizations for release of medical information received must be carefully reviewed for any limitations to the release of medical information.
- Only the portion of the medical record specified in the authorization should be made available to the requestor and should be separated from the remainder of the Member's medical records.
- Notification to Molina of change in client condition, physical or eligibility

Confidentiality and HIPAA

Confidentiality

All Member information, records and data collected, or prepared by the Provider, or provided to the Provider by HHSC or another state agency is protected from disclosure by state and federal laws. The Provider must ensure that all information relating to Members is protected from disclosure except when the information is required to verify eligibility, provide services or assist in the investigation and prosecution of civil and criminal proceedings under state or federal law. The Provider must inform Members of their right to have their medical records and Medicaid information kept confidential.

The Provider must educate employees and Members concerning the human immunodeficiency virus (HIV) and its related conditions including acquired immunodeficiency syndrome (AIDS) and must develop and implement a policy for protecting the confidentiality of AIDS and HIV-related medical information and an anti-discrimination policy for employees and Members with communicable diseases. See also Health and Safety Code, Chapter 85, Subchapter E, relating to Duties of State Agencies and State Contractors.

HIPAA (Health Insurance Portability and Accountability Act) Requirements

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

Provider/Practitioner Responsibilities

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

Applicable Laws

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

1. Federal Laws and Regulations

a. HIPAA
b. Medicare and Medicaid laws

2. TX Medical Privacy Laws and Regulations

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

Uses and Disclosures of PHI

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

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

1. A covered entity may disclose PHI to another covered entity or a healthcare provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services." (See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule.)
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

    - Quality improvement
    - Disease management
    - Case management and care coordination
    - Training Programs
    - Accreditation, licensing, and credentialing

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

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.

Patient Rights

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

- **Notice of Privacy Practices**
  Providers/Practitioners 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/Practitioner should obtain a written acknowledgment that the patient received the notice of privacy practices.

- **Requests for Restrictions on Uses and Disclosures of PHI**
  Patients may request that a healthcare Provider/Practitioner restrict its uses and disclosures of PHI. The Provider/Practitioner is not required to agree to any such request for restrictions.

- **Requests for Confidential Communications**
  Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners must accommodate reasonable requests by the patient.

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

- **Request to Amend PHI**
  Patients have a right to request that the Provider/Practitioner amend information in their designated record set.

- **Request Accounting of PHI Disclosures**
  Patients may request an accounting of disclosures of PHI made by the Provider/Practitioner during the preceding six (6) year period. The list of disclosures

does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

HIPAA Security

Providers/Practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers/Practitioners 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 Healthcare.

HIPAA Transactions and Code Sets

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

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

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at www.molinahealthcare.com for additional information.

Chapter 6 – Abuse, Neglect and Exploitation

Reporting Abuse, Neglect or Exploitation (ANE)

Nursing Facility providers are required to inform members on how to report Abuse, Neglect and Exploitation as defined by HHSC.

Nursing Facility providers are required to train staff how to recognize and report Abuse, Neglect and Exploitation as defined by HHSC.

Medicaid Managed Care

Report suspected Abuse, Neglect and Exploitation:

MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to the Health and Human Services Commission (HHSC) if the victim is an adult or child who reside in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Provider are required to report allegations of ANE to both DFPS and HHSC.
- Adult day care centers; or
- Licensed adult foster care providers

Contact HHSC at (800) 458-9858

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

An adult who is elderly or has a disability, receiving services from:

- Home and Community Support Service Agencies (HCSSAs) – also required to report and HCSSA allegation to HHSC;
- Unlicensed adult foster care provider with three or fewer beds

An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:

- Local intellectual and developmental disability authority (LIDDA), local mental health authority (LMHAs), community center, or mental health facility operated by the Department of State Health Services
- A person who contracts with a Medicaid managed care organization to provide behavioral health services;
- A managed care organization;
- An officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through Consumer Directed Services option.

Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement

If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting

It is a criminal offense if a person fails to report suspected ANE and of person to DFPS, HHSC, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).

It is a criminal offense to knowingly or intentionally report false information to DFPS, HHSC, or a law enforcement agency regarding ANE (See: Texas Human Resource Code, Sec. 48.053; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).

Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or a childcare center.

Chapter 7 – Complaints and Appeals

Definitions

Complainant (1) means a Member or a treating provider or other individual designated to act on behalf of the Member who filed the Complaint. (2) A Provider who has filed a complaint

Member Complaint is an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than a determination of medical necessity for a service as provided by 42 C.F.R §438.400, Possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights. A complaint does not include a matter of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding or providing accurate information to the complainant.

Member Appeal is a formal process by which a Member or his/her representative requests a review of the MCO's Action.

Member Inquiry is a request for information that is resolved promptly by providing the appropriate information; or a misunderstanding that is cleared up to the satisfaction of the Member.

Provider Complaint means an expression of dissatisfaction expressed by a provider, orally or in writing to the MCO, about any matter related to the MCO other than a determination of medical necessity for a service. A provider complaint does not include a matter of misunderstanding or misinformation that can be promptly resolved by clearing up the misunderstanding or providing accurate information to the provider's satisfaction.

Provider Inquiry is a request for information that is resolved promptly by providing the appropriate information; a misunderstanding that is cleared up to the satisfaction of the Provider.

Provider Claims Reconsideration is a dispute or request from a provider to review a claim denial or partial payment. Claim reconsideration includes, but is not limited to, timely filing, contractual payment issues etc.

Provider Claims Appeal is a written request for review of a claim denial or partial payment. All claim appeals must be clearly identified as "Provider Claims Appeal" by written request and be accompanied with all necessary documentation which may include but is not limited to, medical records or if claim was previously reviewed through the reconsideration process. Molina would encourage providers to submit claims reconsideration prior to submitting a formal written claims appeal.

STAR+PLUS and MMP Member Complaint Process

<u>What should members do if they have a complaint? Who do they call?</u>

We want to help. If a member has a complaint, they can call us toll-free to tell us about their problem. A Molina Member Services Representative can help them file a complaint. Most of the time, we can help members right away, or at the most, within a few days.

Member Services Toll Free: (866) 449-6849 (Medicaid)/(866) 856-8699 (MMP)

Once a member has gone through the Molina complaint process, they can complain to the Health and Human Services Commission (HHSC) by calling toll-free (866) 566-8989. If the member would like to make their complaint in writing, they can send it to the following address:

Texas Health and Human Services Commission
Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

If a member can get on the Internet, they can send their complaint in an email to HPM_Complaints@hhsc.state.tx.us.

Nursing Facility STAR+PLUS and MMP Members may also complain to:

Texas Long Term Care Ombudsman Program
1-800-252-2412.

If a member can get on the Internet, they can send their complaint in an email to:
ltc.ombudsman@hhsc.state.tx.us

Can someone from Molina help members file a complaint?

Yes, we want to help members with the complaint process. When members have a complaint, they can call our Member Services Department. They will help members file the complaint. They will also be members' contact throughout the complaint process.

Member Services Toll Free: (866) 449-6849 (Medicaid)/(866) 856-8699 (MMP)

Members can send the complaint in writing to:

Medicaid	MMP
Molina Healthcare of Texas Attention: Member Inquiry Research and Resolution P.O. Box 182273 Chattanooga, TN 37422	Molina Dual Options STAR+PLUS MMP Attn: Grievances and Appeals P.O.Box 22816 Long Beach, CA 90801-9977

How long will it take to process a complaint?

Member complaints will be processed within (30) calendar days or less, from the date Molina gets the complaint.

Requirements and timeframes for filing a Complaint:

- When we get a complaint, we will send the member a letter within five days telling them we have their complaint.
- We will look into the complaint and decide the outcome. We will send the member a letter telling them the final outcome. We will not take more than (30) calendar days to complete this process.
- We will keep track of all of complaint information in a complaint log. If members need more information on their complaint, they can call Member Services.

STAR+PLUS and MMP Member Appeal Process

What can I do if the MCO denies or limits my Member's request for a Covered Service?

Members can request an appeal for denial of payment for services in whole or in part.

Members can file an appeal orally or in writing with Molina anytime a service is denied or limited. Members will need to file the appeal within 60 calendar days from the day they get a letter telling them a service was denied or limited. If a member is currently getting services and the service is now being denied or limited, they will need to file their appeal within (10) calendar days from the day they get a letter telling them the service is being denied or limited to continue receiving their the service. Please note that the Member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member.

How will members find out if services are denied?

We will send members a letter telling them a service has been denied.

What happens after a member files an appeal?

Once we have an appeal, we will send the member a letter within (5) business days telling them we have their appeal and it is being worked on. The letter will also tell members that they can ask for a State Fair Hearing any time after the appeal process with Molina is complete. Molina will then review the information about their appeal. We may need to ask for more information from the member or their doctor to help us make a decision. Members can review the information about their appeal at any time. Members can also appear in person, by telephone

or tell us about their appeal in writing. Once the final decision is made, we will send the members and the member's doctor a letter with the final decision. This process will not take more than then (30) calendar days. Members have the option to request an extension up to 14 calendar days. Sometimes Molina may need more information. If this happens we may extend the appeals process by 14 days.

If we extend the appeals process, we will inform you in writing. This letter will let you know the reason for the delay.

Who Do Members Call?

Members can call Member Services and tell them they would like to file an appeal. Member Services will help members file the appeal and give them updates during the appeal process.

Member Services Toll Free: (866) 449-6849 (Medicaid)/ (866) 856-8699 (MMP)

Members can also write their appeal and send it to:

Medicaid	MMP
Molina Healthcare of Texas Attention: Member Inquiry Research and Resolution P.O. Box 182273 Chattanooga, TN 37422	Molina Dual Options STAR+PLUS MMP Attn: Grievances and Appeals P.O. Box 22816 Long Beach, CA 90801-9977

Can someone from Molina help members file an appeal?

Someone in Member Services can help members file their appeal. Members should just ask for help when they call to file their appeal.

Members can also request a State Fair Hearing and External Medical Review within 120 days after Molina mails the internal appeal decision notice. Members also have the option to request only a State Fair Hearing (without an External Medical Review) within 120 days after Molina mails the internal appeal decision notice.
(See State Fair Hearing/External Medical Review below for more information)

Emergency Appeal STAR+PLUS and MMP

What is an emergency appeal?

An Emergency Appeal is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

How do members ask for an emergency appeal?

Members can call Member Services and ask to file an emergency appeal. We will help them. An Expedited Appeal may be requested either orally or in writing.

Member Services Toll Free: (866) 449-6849 (Medicaid)/ (866) 856-8699 (MMP)

Members can also write their appeal and send it to:

Medicaid	MMP
Molina Healthcare of Texas Attention: Member Inquiry Research and Resolution P.O. Box 182273 Chattanooga, TN 37422	Molina Dual Options STAR+PLUS MMP Attn: Grievances and Appeals P.O. Box 22816 Long Beach, CA 90801-9977

What are the time frames for an emergency appeal?

Molina will make a decision on an emergency appeal within (3) business days. An appeal can also be extended up to (14) calendar days, to gather more information, if it is in the member's best interest to do so. Members will be notified if an extension is needed by phone and they will get a letter within two business days.

If there is a risk to a member's life, a decision will be made within 24 hours from the time Molina gets the expedited appeal.

What happens if Molina denies the request for an emergency appeal?

Molina may make a decision that an appeal should not be expedited. If this decision is made, we will follow the standard appeal process. As soon as this is decided, we will try to call the member to let them know the standard appeal process will be followed. We will also send the member a letter within (2) calendar days with this information.

Who can help members file an Emergency Appeal?

You can call Member Services and ask for help filing an emergency appeal. We will know to work on it very quickly.

State Fair Hearing/External Medical Review Information

Can a member ask for a State Fair Hearing?

If a Member, as a Member of the health plan, disagrees with the health plan's decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent them by contacting the health plan giving the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the Member does not ask for the State Fair Hearing within 120 days, the Member

may lose his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member's representative should either send a letter to the health plan at:

Medicaid	MMP
Molina Healthcare of Texas Attention: Member Inquiry Research and Resolution P.O. Box 182273 Chattanooga, TN 37422	Molina Dual Options STAR+PLUS MMP Attn: Grievances and Appeals P.O. Box 22816 Long Beach, CA 90801-9977

Or call: (866) 449-6849 (Medicaid)/ (866) 856-8699 (MMP)

If the Member asks for a State Fair Hearing within 10 days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the Member does not request a State Fair Hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

If the Member asks for a State Fair Hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most State Fair Hearings are held by telephone. At that time, the Member or the Member's representative can tell why the Member needs the service the health plan denied.

HHSC will give the Member a final decision within 90 days from the date the Member asked for the hearing.

If the member loses the state fair hearing appeal, Molina may be able to recover the costs of providing the service or benefit to you while the appeal was pending.

Can a member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A provider may be the Member's representative if the provider is named as the Member's authorized representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to Molina by using the address or fax number at the top of the form.;
- Call the MCO at (866) 449-6849;
- Email the MCO at TXMemberInquiryResearchAndResolution@MolinaHealthCare.Com, or;

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an independent review organization or while the independent review organization is reviewing your External Medical Review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an independent review organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling Molina. To qualify for an emergency External Medical Review and emergency State Fair Hearing the Member must first complete Molina's internal appeals process.

Appeals of Medicare Benefits (MMP Only)

- Appeals of Medicare benefits are automatically sent to by the Plan to the Medicare Independent Review Entity (IRE) if the Plan upholds the initial denial.
- If the physician conducting the reconsideration upholds the original determination, the determination is forwarded to the Independent Review Organization (IRO). Molina staff prepares the denial file and forwards to the IRO within the established timeframes and with the required information. If IRO review upholds the adverse determination by Molina, enrollees are advised of their further appeal rights and choices. Details for these appeal processes are described in the Appeals Policy and Procedure.
- The third level of appeals for Medicare benefits are filed with the Office of Medicare Hearings and Appeals (OMHA).

What is an Independent Review Organization (IRO)?

An IRO reviews the medical necessity of health care services. It is not part of Molina. It has no connection with our providers. Their decision is final.

Appeals for Level of Care Determinations

HHSC's Administrative Services Contractor – TMHP is responsible to determine whether the Member meets medical necessity criteria for nursing facility admissions. should have a Medicaid service asked for but did not get.

If TMHP denies a Member a MDS Medical Necessity Level of Care, the Member and the NF will be notified by mail from TMHP. The letter will include information regarding rights to a State Fair Hearing.

Upon request by the Member, the Service Coordinator will work with the NF staff to prepare documentation to support the Member's appeal. Supporting documentation will be submitted to TMHP by the Service Coordinator with the approval of the Member. If requested, the Service Coordinator will make every effort to attend the State Fair Hearing with and on behalf of the member.

A State Fair Hearing is a chance for the member to tell TMHP the reasons they think The member can ask for a State Fair Hearing within 120 days of the date of the letter that said the member could not get the service.

A member can ask for a State Fair Hearing by calling 1-800-727-5436 or 1-800-626-4117. Pick Option 5.

If the member would like to make a request in writing, send it to the following address:

Texas Medicaid & Healthcare Partnership (TMHP)
Attention: Medical Affairs Support, MC A13
PO Box 204270
Austin, TX 78720-4270

After TMHP gets the member phone call or letter, a hearing officer will send the member a letter. The letter will tell the member the date and time of the hearing. It also will tell the member what they need to know to get ready for the hearing. The hearing can take place by phone or in person

During the Hearing:

The member can explain why they asked for the service that they didn't get. Members can speak for themselves. Or members can ask someone else to speak for them. This could be a friend, family members, or lawyer. The hearing officer will listen to what is said regarding the denial of services. The member may ask questions and the hearing officer might ask the member some questions. A final decision will be made within 90 days from the date the member asked for the hearing.

Provider Complaints and Appeals – STAR+PLUS and MMP

Nursing Facility Providers are assigned a Nursing Facility Provider Services Representative (NF PSR) who is available to assist the NF in any claims or claims payment related issues. Molina highly encourages NF's to contact their assigned NF PSR directly to resolve any claims or claims payment related issues.

To find out who is your assigned NF PSR, email: NFProviderServices@Molinahealthcare.com

Nursing Facilities always have the option of following the formal complaint process.

Provider Complaints

A provider has the right to file a complaint with Molina Healthcare at any time. The provider also has the right to file a complaint directly with HHSC after completing Molina's complaint process.

How to file a STAR+PLUS and/or MMP Complaint:

A complaint can be oral or written:

MOLINA	HHSC
Call: (866) 449-6849	**Call:** 1-800-252-8263
Write to: Molina Healthcare of Texas Attention: Complaints and Appeals Dept. P.O. Box 182273 Chattanooga, TN	**Write to:** HHSC Po Box 85200 Austin, TX 78708 or HPM_Complaints@hhsc.state.tx.us
Fax to: (877) 319-6852	

Complaints/Appeals can also be submitted online via the Provider Portal (https://provider.molinahealthcare.com/Provider)

Documentation

- All Complaint/Appeal Fax Cover Pages and emails to and from Molina regarding Provider complaints/appeals are stored and archived by Molina Healthcare.
- Telephone communication logs are tracked and stored in Molina Healthcare's Appeals and Grievances Database

Complaint Timeframes:

- A provider can file a complaint anytime.
- When a complaint is received verbally, Molina will send an acknowledgement letter along with a one-page complaint form within 5 business days.
- When Molina Healthcare receives a written complaint from a provider, we will send an acknowledgement letter to the provider within 5 business days.
- Complaints will be investigated, addressed, and the provider will be notified of the outcome, in writing, within 30 calendar days from the date the complaint is received by Molina Healthcare.

Provider Appeal Process

Appeal means the formal process by which a Provider requests a review of the MCO's Action.

Action means:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial in whole or in part of payment for services;
- The failure to provide services in a timely manner;

- The failure of an MCO to act within the timeframes set forth in the contract; or
- For a resident of a rural area with only one MCO, the denial of a Medicaid Members' request to obtain services outside of the Network.

How to file an appeal:

An appeal must be filed in writing.

STAR+PLUS and/or MMP

MOLINA
Write to: Molina Healthcare of Texas Attention: Complaints and Appeals Dept. P.O. Box 182273 Chattanooga, TN 37422
Fax to: (877) 319-6852

Complaints/Appeals can also be submitted online via the Provider Portal (https://provider.molinahealthcare.com/Provider)

Documentation

- All Complaint/Appeal Fax Cover Pages and emails to and from Molina regarding Provider complaints/appeals are stored and archived by Molina Healthcare.
- Telephone communication logs are tracked and stored in Molina Healthcare's Appeals and Grievances Database

Appeal Timeframes:

- The provider or practitioner is allowed **120 days** from the date of the initial denial notification to submit an appeal.
- Provider appeals should be resolved within 30 calendar days of Molina's receipt of the appeal.

Additional Resolution Options

Dissatisfied with STAR, STAR+ PLUS Complaint or Appeal Outcome?

Upon receipt of the **STAR+PLUS or MMP** complaint outcome, if the provider is still dissatisfied, the provider may contact HHSC for further resolution. For more information:

Call HHSC at: (512) 338-6569; Fax: (512) 794-6815; or
E-mail: provider.resolutions@hhsc.state.tx.us
Texas Health and Human Services Commission
Medical Appeals and Provider Resolution Division, Y-929
1100 West 49th Street
Austin, TX 78756-3172

Chapter 8 – STAR+PLUS and MMP Eligibility

Medicaid Eligibility Determination

HHSC is responsible for determining eligibility in the Texas Medicaid program.

Verifying Medicaid Eligibility

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the Member has current Medicaid coverage. A provider should verify the Member's eligibility for the date of service before rendering services. There are three ways to do this:

- Call Molina or check Molina Provider Portal.
- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Log into your TMHP user account and accessing Medicaid Client Portal for providers
- Call TMHP Contact Center or the Automated Inquiry System (AIS) at 1-800-925-9126 or 1-512-335-5986
- Your Texas Benefits Medicaid Card
    - Temporary ID (Form 1027-A)
    - Molina ID Card
        - STAR+PLUS Dual Eligible - If the Member gets Medicare, Medicare is responsible for most primary, acute, and behavioral health services. Therefore, the Primary Care Provider's name, address, and telephone number are not listed on the Member's ID card. The Member receives long-term services and supports through Molina Healthcare.

Molina Dual Options STAR+PLUS MMP Eligibility

Who is Eligible?

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

- Age 21 or older at the time of enrollment;
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits;
- Required to receive their Medicaid benefits through the STAR+PLUS program as further outlined in HHSC's existing Texas Healthcare Transformation and Quality Improvement

Program section 1115(a) demonstration. Generally, these are individuals who are age 21 or older who:

  - Have a physical disability or a mental disability and qualify for SSI, or
  - Qualify for Medicaid because they receive Home and Community Based Services (HCBS) STAR+PLUS Waiver Services
- Reside in one of the Demonstration counties

Verifying Eligibility

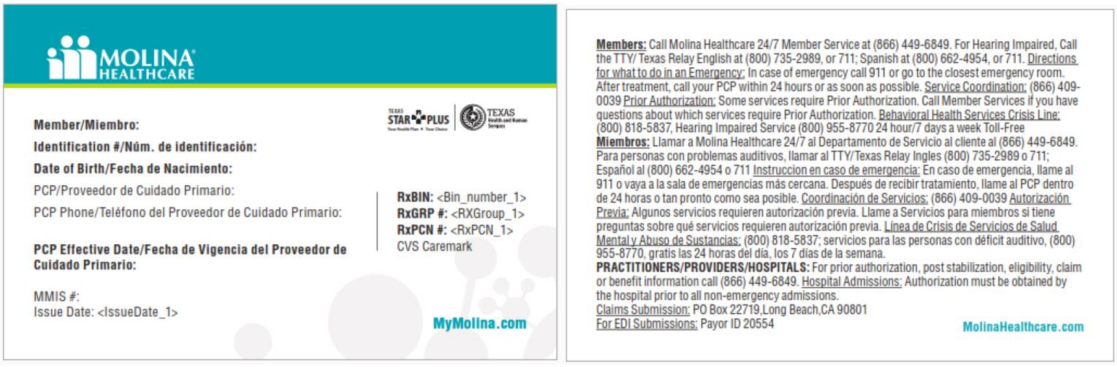
Verification of enrollment and eligibility status is necessary to ensure payment for healthcare services being rendered by the provider to the enrollee. Molina's Dual Option STAR+PLUS MMP strongly encourages providers to verify eligibility at every visit and especially prior to providing services that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

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

Molina ID Cards

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

STAR+PLUS
STAR+PLUS Medicaid Only

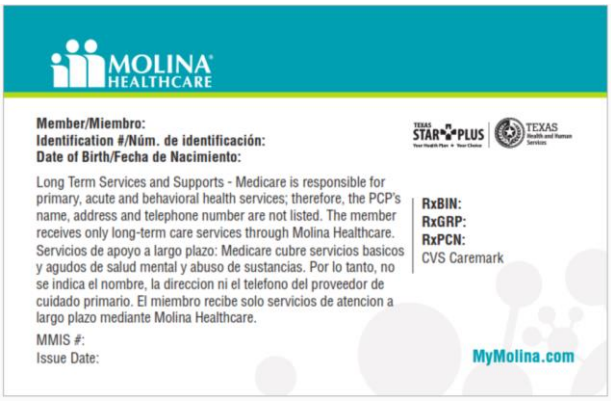


KEY TO Molina ID Cards

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

STAR+PLUS Dual Eligible (Traditional Medicare)

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



KEY to Molina ID Cards

- Molina Healthcare Logo
- Molina Healthcare Member Services phone numbers
- Patient Information
- Behavioral Health Hotline number
- Program the Member is enrolled in
- Long Term Services and Supports
- Information on who to call in an emergency
- Name and address to which you must submit your claims

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

KEY to Molina ID Cards

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

Chapter 9 – Member Rights and Responsibilities

Member Rights

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect
   b. Know that your medical records and discussions with your providers will be kept private and confidential.

2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your primary care provider.
   b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   c. Change your primary care provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your primary care provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated,
   b. Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.

5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan's appeal process and be told how to use it.
   d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.

a. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and get information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Members' right to select eye health care provider

Members have the right to select and have access to, without a Primary Care Provider referral, a network ophthalmologist or therapeutic optometrist to provide eye health care services other than surgery.

Access to Specialists

Members with disabilities, special health care needs, or chronic or complex conditions are allowed direct access to a specialist.

Specialist as PCP

Nursing Facility Member have the right to designate a specialist as their PCP as long as the specialist agrees. See PCP as a Specialist in *Chapter 1 Roles and Responsibilities..*

Pharmacy of Choice

Members have the right to obtain medication from any Network pharmacy.

Members' right to designate an OB/GYN

Molina Healthcare *DOES NOT LIMIT* TO NETWORK

Molina Healthcare allows the Member to pick any OB/GYN, whether that doctor is in the same network as the Member's Primary Care Provider or not.

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the Member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

Member Responsibilities

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.
   c. Learn what choices of health plans are available in your area.

2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan's rules and Medicaid rules.
   b. Choose your health plan and a primary care provider quickly.
   c. Make any changes to your health plan and primary care provider in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your primary care provider first for your non-emergency medical needs.
   g. Be sure you have approval from your primary care provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health.

b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
c. Help your providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
   a. Work as a team with your provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your provider about all of your medications

Chapter 10 – Billing and Claims Administration

Role of the Provider Services Representative

The Provider Relations Representative (PRR) is a representative of Molina who is proficient in Nursing Facility billing matters and is able to resolve billing and payment inquiries. The PSR will establish routine contact with the billing office of the NF Provider providing training, billing and payment resolution by working with the Molina claims processing department.

Molina will provide the name and contact information of the PSR within 3 days of the effective contract. Additionally, Molina will notify the Provider within ten days of any changed to the assigned PRR.

The PRR will return a call regarding billing and payment matters no later than 72 hours after the Provider places the call.

Nursing Facilities with questions about claims, claims processing or payment they have received related to a claim should contact their assigned NF Provider Relations Representative (PRR) or may email: NFProviderServices@Molinahealthcare.com

To obtain the name and contact information for the PRR assigned to a nursing facility email: NFProviderServices@Molinahealthcare.com

Billing, Claims, and Encounter Data Administration

Molina does not have a capitation relationship with providers. As a contracted provider, it is important to understand how the claims process works to avoid delays in the processing of your claims.

Electronic Claims Required

Nursing Facility Providers are required to submit claims electronically through a clearing house, the HHSC designated portal or Molina's Provider Portal.

Claims Submission

Participating Providers are required to submit claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse, the HHSC designated portal or Molina's Provider Portal, and use current HIPAA compliant ANSI X 12N

format (e.g., 837I for institutional Claims, 837P for professional Claims) and use electronic Payer ID number: 20554.

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

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers should also include the appropriate taxonomy on claims submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed thirty (30) calendar days from the change.

Electronic Claims Submission Guidelines

Electronic claims must be submitted to Molina using the appropriate Professional and Institutional Encounter guides as shown below;

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

Electronic claims that meet the clean claim requirements as defined in the 28 Tex. Admin. Chapter 21 Subchapters C and T will be paid or denied within thirty (30) days of receipt excluding Nursing Facilities (NF) Daily Unit Rate claims will be paid or denied within ten (10) days of receipt.

Molina shall pay Network Providers interest at a rate of 1.5% per month (18% per annum) on all clean claims that are not paid within 30 days or 10 days for NF Daily Unit Rate. Claims that do not meet the requirements of a clean claim will still be paid or denied in a timely manner where possible, but Molina will not be liable for any late-payment penalties on claims that do not meet the requirements of a clean claim.

Molina offers the following electronic Claims submission options:

- Submit claims through HHSC designated portal
- Submit Claims directly to Molina via the Provider Portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 20554

HHSC designated portal

Nursing Facilities may only submit NF Unit Rate and Medicare Part A co-insurance claims through the HHSC designated portal.

Provider Portal

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

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

Clearinghouse:

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

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. In order to ensure that all data being submitted to our gateway is received properly, your submitter must utilize the latest version of the 837 standard. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

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

EDI Claims Submission Issues

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

Changes to Claim Guidelines

Molina will notify Nursing Facility Network Providers in writing of any changes in the list of claims processing or adjudication entities at least ninety (90) days prior to the effective date of change. If Molina is unable to provide at least ninety (90) days notice, the Molina will give

Network Providers a 90-day extension on their claims filing deadline to ensure claims are routed to correct processing centers.

Batch Claims

Batch claims may be submitted via the EDI link on the Molina Provider Portal

Electronic Claim Payment

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

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

COB

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

TPL

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

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

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

Billing the Member

NF Providers must inform members of Covered Services and the costs for non-covered services prior to rendering these services, by obtaining a signed private pay form from the Member.

Requirements for a Clean Claim – Nursing Facilities Daily Unit Rate

Claims submitted for Nursing Facility Daily Unit Rate must meet the HHSC criteria for clean claims submission as described in Uniform Managed Care Manual 2.3, "Nursing Facility Claims Manual"

- The Nursing Facility resident must be Medicaid eligible for the dates of service billed;
- The Nursing Facility resident must be in the Nursing Facility for the dates of service billed;
- The Nursing Facility resident must have a current Medical Necessity determination for the dates of service billed; and
- The Nursing Facility Provider had to be in good standing for the dates of service billed (i.e., not on vendor payment hold for any reason).

Requirements for a Clean Claim - Institutional Providers

- MMP Skilled Nursing Facility (SNF) Daily Rate stay claims
- MMP therapy and other ancillary services/supplies/ STAR+PLUS Add-On Services

Claims must be submitted on UB-04 form.

UB-04

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

Information regarding the revised form may also be found on the CMS website: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf.

Molina Required/Requested NPI Fields

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

Required data elements for institutional providers are listed as follows:

1. Provider's name, address and telephone number (UB-04, field 1)
2. Pay to Provider's name, address and telephone number (UB-04, field 2) Optional, use if pay to address is different from address in field 1.
3. Patient control number (UB-04, field 3)
4. Type of bill code (UB-04, field 4) is required and shall include a "7" in the third position if the claim is a corrected claim.
5. Provider's federal tax ID number (UB-04, field 5)
6. Statement period (beginning and ending date of claim period) (UB-04, field 6)
7. Covered days (UB-04, field 7), is required if Medicare is a primary or secondary payor
8. Patient's name (UB-04, field 8)
9. Patient's address (UB-04, field 9)
10. Patient's date of birth (UB-04, field 10)
11. Patient's gender (UB-04, field 11)
12. Date of admission (UB-04, field 12) is required for admissions, observation stays, and emergency room care
13. Admission hour (UB-04, field 13) is required for admissions, observation stays, and emergency room care
14. Type of admission (e.g., emergency, urgent, elective, newborn) (UB-04, field 14)
15. Source of admission code (UB-04, field 15)
16. Discharge hour (UB-04, field 16), required for hospital admissions, outpatient surgeries or observation stays
17. Patient-status-at-discharge code (UB-04, field 17) is required for admissions, observation stays, and emergency room care
18. Condition codes (UB-04, fields 18-28), required if appropriate
19. Occurrence codes and all dates (UB-04, fields 31-34) required if appropriate

20. Occurrence span codes, from and through dates (UB-04, fields 35-36) required if appropriate
21. Value code and amounts (UB-04, field 39-41) required for inpatient admissions, If no value codes are applicable to the inpatient admission, the provider may enter value code 01
22. Revenue code (UB-04, field 42)
23. Revenue description (UB-04, field 43)
24. HCPCS/Rates (UB-04, field 44) required if Medicare is a primary or secondary payor
25. Service date (UB-04, field 45) required if the claim is for outpatient services
26. Units of service (UB-04, field 46)
27. Total charge (UB-04, field 47) not applicable for electronic billing
28. Non-Covered charge (UB-04, field 48) required if information is available and applicable
29. Payor identification (UB-04, field 50)
30. Health Plan identifier number (UB-04, field 51) required
31. Release of information indicator (UB-04, field 52) required.
32. Prior payments-payor and patient (UB-04, field 54) required if payments have been made to the physician or provider by the patient or another payor or subscriber, on behalf of the patient or subscriber.
33. Billing provider name and identifiers, including NPI (UB-04, field 56) required on all claims.
34. Other Provider ID (UB-04, field 57) Required, Texas providers should include their TPI in this field.
35. Insured's name (UB-04, field 58) is required if shown on the patient's ID card
36. Patient's relationship to insured (UB-04, field 59)
37. Insured's unique ID number (UB-04, field 60), required, shown on patient's ID card.
38. Insurance Group Name (UB-04, field 61) required if shown on patient's ID card.
39. Insurance group number (UB-04, field 62), required if shown on patient's ID card
40. Treatment authorization codes (UB-04, field 63) required if services have been authorized.
41. Diagnosis and procedure code qualifier (UB-04, field 66)
42. Principle diagnosis code (UB-04, field 67) Required on all claims
43. Diagnoses codes other than principal diagnosis code (UB-04, field 67A-Q), are required if there are diagnoses codes other than principal diagnosis.
44. Admitting diagnosis code (UB-04, field 69)
45. Patient's reason for visit (UB-04, field 70), required for unscheduled outpatient visits
46. Principal procedure code (UB-04, field 74) required if the patient has undergone an inpatient or outpatient surgical procedure
47. Other procedure codes (UB-04, fields 74A-E), are required as an extension of "46" if additional surgical procedures were performed
48. Attending physician name and identifiers, including NPI (UB-04, field 76) Required on all claims

49. Operating Physician name and identifier, including NPI (UB-04, field 77) Required only when surgical procedure on claim
50. Other providers name and identifiers, including NPI (UB-04, fields 78-79) Requested if information is available

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

- MMP therapy and other ancillary services/supplies/
- STAR+PLUS Add-On Services

CMS Form 150

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

Required NPI Fields

CMS-1500	Field Location	Required
Referring Provider	Box 17b	Requested*
Rendering Provider	Box 24j	**Required**
Facility	Box 32a	Requested*
Billing Provider	Box 33a	**Required**
LTSS Provider Only	Box 33b	**Required**

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

1. Subscriber's/patient's plan ID number (CMS 1500, field 1a)
2. Patient's name (CMS 1500, field 2)
3. Patient's date of birth and gender (CMS 1500, field 3)
4. Subscriber's name (CMS 1500, field 4) is required, if shown on the patient's ID card
5. Patient' address (street or P.O. Box, city, state, zip) (CMS 1500, field 5) is required
6. Patient's relationship to subscriber (CMS 1500, field 6)
7. Subscriber's address (street or P.O. Box, city, state, zip) (CMS 1500, field 7) required but physician or provider may enter "same" if the subscriber's address is the same as the patient's address required by requirement "E"
8. Subscriber's policy number (CMS 1500, field 11)
9. MCO or insurance company name (CMS 1500, field 11c)

10. Disclosure of any other health benefit plans (11d)
11. Patients or authorized person's signature or notation that the signature is on file with the physician or provider (CMS 1500, field 12)
12. Subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (CMS 1500 field 13)
13. Date of injury (CMS 1500, field 14) is required, if due to an accident
14. Name of referring physician or other source (CMS 1500, field 17) is required for primary care physicians, specially physicians and hospitals; however, if there is no referral, the physician or provider shall enter "Self-referral" or "None".
15. I.D. Number of referring physician (CMS 1500 field 17a) is required for primary care physicians, specialty physicians and hospitals; however, if there is no referral, the physician or provider shall enter "Self-referral" or "None".
16. Narrative description of procedure (CMS 1500, field 19) is required when a physician or provider uses an unlisted or not classified procedure code or an NDC code for drugs.
17. For diagnosis codes or nature of illness or injury (CMS 1500, field 21), up to four diagnosis codes may be entered, but at least one is required (Primary diagnosis must be entered first);
18. Verification number (CMS 1500, field 23), is required if services have been verified. If no verification has been provided, a prior authorization number (CMS 1500, field 23), is required when prior authorization is required and granted;
19. Date(s) of service (CMS 1500, field 24A)
20. Place of service codes (CMS 1500, field 24B)
21. Procedure/modifier code (CMS 1500, field 24 D)
22. Diagnosis code by specific service (CMS 1500, field 24E) is required with the first code linked to the applicable diagnosis code for that service in field 21
23. Charge for each listed service (CMS 1500, field 24F)
24. Number of days or units (CMS 1500, field 24G)
25. NPI of Rendering physician or provider in box 24j and Billing Provider NPI in box 33a (CMS 1500).
26. Federal tax id in box 25 (CMS 1500).
27. Whether assignment was accepted (CMS 1500, field 27), is required if assignment under Medicare has been accepted.
28. Total charge (CMS 1500, field 28)
29. Amount paid, (CMS 1500, field 29), is required if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber.
30. Signature of physician or provider or notation that the signature is on file with the MCO or preferred provider carrier (CMS 1500, field 31)
31. Name and address of facility where services rendered (if other than home or office) (CMS 1500, field 32,)
32. Physician's or provider's billing name, address and telephone number is required, and the provider number (CMS 1500, field 33, 12-90 version) is required if the MCO or preferred provider carrier required provider numbers and gave notice of that requirement to

physicians and providers prior to June 17, 2003. For CMS 1500 08-05 version, physician's or provider's **billing** NPI number should be in field 33a.

Nursing Facility Unit Rate Claims

Nursing Facility Unit Rate means the types of services included in the HHSC daily rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services and over-the-counter drugs. The Nursing Facility Unit Rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. Nursing Facility Unit Rate excludes Nursing Facility Add-on Services.

Contact Molina Healthcare at 866-449-6849 or email NFProviderServices@Molinahealthcare.com for further information or questions.

Claims submitted for the Nursing Facility Unit Rate will be authorized by HHSC. Molina will not reassess or authorize services resulting from the MDS and covered under the Nursing Facility Unit Rate.

Nursing Facility Unit Rate claims may be filed through the provider's clearinghouse, the HHSC designated provider portal or the Molina Provider Portal.

Nursing Facility Unit Rate Filing Deadlines

Nursing Facility Providers must file Nursing Facility Unit Rate claims by the later of:

- 365 Days after the date of service; OR
- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor

If the Nursing Facility Provider files a claim for Nursing Facility Unit Rate with a third-party insurance resource, the wrong health plan, or with the wrong HHSC portal, and produces documentation verifying that the initial filing met the timeliness standard cited above, Molina will process the claim without denying the resubmission for failure to timely file. The NF Provider must file the claim by the later of:

- 365 Days after the date of service; OR
- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor

Nursing Facility Unit Rate Claims not submitted with 365 days of service or within 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor will be denied for failure to file timely.

Nursing Facility Unit Rate Claims Adjudication

Molina will Adjudicate Clean Claims for the Nursing Facility Unit Rates no later than 10 days after the submission to the Molina portal or HHSC's designated portal, whichever occurs first.

Appeal of a Nursing Facility Unit Rate Claim

The Nursing Facility is allowed **120 days** from the date of the initial denial notification to submit an appeal. See *Chapter 7 Complaints and Appeals*

Nursing Facility Unit Rate Previously Adjudicated Claims - Auto-Adjusted Claims

Molina will make auto-adjustments to previously adjudicated claims within 30 days from the date of receipt of an adjustment from HHSC to reflect changes to such things as:

- Nursing Facility Daily Rate
- Provider Contracts
- Service Authorizations
- Applied Income
- Level of Service (RUG)

Applied Income

Applied Income is the portion of the earned and unearned income of the STAR+PLUS Member, or if applicable the Member and the Member's spouse, that is paid under the Medicaid program to an institution or long-term care facility in which the member resides. HHSC will determine the amount of the applied income. The Nursing Facility is responsible for the collection of monthly Applied Income. Applied Income is to be prorated as based on the number of days in the month.

The Provider must make reasonable efforts to collect Applied Income, document those efforts and notify the Service Coordinator or Molina's designated representative when it has made two unsuccessful attempts to collect applied income in a month. This provision in no way subrogates the Provider's existing regulatory and licensing responsibilities related to the collection of applied income, including the requirements of 40. TAC 19.2316.

Nursing Facility Add-on Services Claims

Nursing Facility providers delivering Rehabilitative (PT, OT, ST) add on services (including assessments) must be billed separate from Nursing Facility Unit Rate claims. Nursing Facility Add-on Services must be pre-authorized per Molina policy (see Chapter 8 Authorization and Utilization)

For Nursing Facility Add-on therapy services, Molina will accept claims received from:

- The Nursing Facility on behalf of employed or contracted therapist; and
- Directly from contracted therapist who are contracted with Molina

All other Nursing Facility Add-on Services providers must contract directly with and directly bill Molina. Nursing Facility Add-on providers (except NF Add-on therapy service providers) must refer to the Molina STAR+PLUS Provider manual for prior authorization, claims and credentialing information.

Nursing Facility Add-on services claims may be filed through the provider's clearinghouse, or the Molina Provider Portal.

Nursing Facility Add-On claims for therapy services must include revenue codes, CPT/HCPCS codes and Modifiers from the Long-Term Care Bill Code Crosswalk. Modifiers must include the procedure modifier (U1/UA) and the location modifier (GN/GO/GP). For Modifier Requirements, please refer to the LTSS Billing Code Matrix, NF Section (The Long-Term Care Bill Code crosswalk), a cross-referenced code set used to match the Texas Long-term Care (LTC) Local Codes (i.e., bill codes) to the National Standard Procedure Codes. See https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/long-term-care-bill-code-crosswalks

Nursing Facility Add-on Services Filing Deadlines

Nursing Facility Providers must file Nursing Facility Add-on Services claims by the later of:

- 95 Days after the date of service; OR
- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor

If the Nursing Facility Provider files a claim for Add-On Services with a third-party insurance resource, the wrong health plan, or with the wrong HHSC portal, and produces documentation verifying that the initial filing met the timeliness standard cited above, Molina will process the claim without denying the resubmission for failure to timely file. The NF Provider must file the claim by the later of:

- 95 Days after the date of service; OR
- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor

Nursing Facility Add-On Service claims not submitted with 95 days of service or within 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor will be denied for failure to file timely.

Nursing Facility Add-on Service Clean Claim Adjudication

Electronic claims for Nursing Facility Add-on services by professional or institutional providers that meet the clean claim requirements as defined in the 28 Tex. Admin. Chapter 21, Subchapters C and T will be paid or denied within thirty (30) days of receipt.

Appeal of Nursing Facility Add-on Service Claim

NF Add-on Service provider's is allowed 120 days from the date of the initial denial notification to submit an appeal. *See Chapter 7 Complaints and Appeals.*

Nursing Facility Medicare Coinsurance Claim

Molina will pay HHSC's Medicare coinsurance obligation for a qualified Dual Eligible Member's Medicare-covered stay in a Nursing Facility. Molina is not responsible for HHSC's cost sharing obligation for a Dual Eligible Member's Medicare-covered Nursing Facility Add-on Services, which are adjudicated by either HHSC's fee-for-service claims administrator or the Dual Eligible Member's Medicare plan, as applicable to the Member.

The Nursing Facility must submit an electronic version of the Medicare Remittance and Advice form with the Nursing Facility Coinsurance claim.

Nursing Facility Medicare Coinsurance claims may be filed through the provider's clearinghouse, the HHSC designated provider portal or the Molina Provider Portal.

Nursing Facility Medicare Coinsurance claims must be separately from NF Daily Unit Rate, MMP SNF Daily Rate and MMP Outpatient (Part B) claims

Nursing Facility Medicare Coinsurance Claim Deadlines

Nursing Facility Providers must file Nursing Facility Medicare Coinsurance claims by the later of:

- 365 Days after the date of service; OR
- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor

If the Nursing Facility Provider files a claim for Nursing Facility Medicare Coinsurance with a third-party insurance resource, the wrong health plan, or with the wrong HHSC portal, and produces documentation verifying that the initial filing met the timeliness standard cited above, Molina will process the claim without denying the resubmission for failure to timely file. The NF Provider must file the claim by the later of:

- 365 Days after date of service; OR

- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor

Nursing Facility Coinsurance Claims not submitted with 365 days of service or within 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor will be denied for failure to file timely.

Nursing Facility Medicare Coinsurance Clean Claim Adjudication

Molina will Adjudicate Nursing Facility Coinsurance clean claims no later than 10 days after the submission to the Molina portal or HHSC's designated portal, whichever occurs first.

Appeal of Nursing Facility Co-insurance Claim

Nursing Facility is allowed 120 days from the date of the initial denial notification to submit an appeal. *See Chapter 7 Complaints and Appeals.*

MMP Skilled Nursing Facility (SNF) Daily Rate Claims (Medicare Part A)

The 3-midnight hospital stay requirement is waived and does not apply to MMP members Skilled Nursing Facility stays require Prior Authorization. This applies to:

- Initial SNF stays
- Continued SNF stays
- "Skilling-in-Place" stays
- Re-admission SNF stays for members returning to the same facility

NF Providers must submit a claim for a Skilled Nursing Facility (SNF) Daily Rate stay:

- SNF Daily Rate Claims must be filed electronically utilizing the Molina Provider Portal or a provider's clearinghouse, the HHSC designated portal will not process SNF claims.
- SNF Daily Rate Claims must be filed separately from NF Unit Rate, NF Add-On Services, Medicare Coinsurance and MMP Outpatient services (Part B) claims.
- SNF Daily Rate Claims should follow the previously identified guidelines for an institutional claim utilizing the Minimum Data Set (MDS) Resource Utilization Group (RUG) as the basis for the claim rate.
- Molina will adjudicate the Medicare portion of the claim, automatically create a coinsurance claim and pay both the Medicare and Medicaid claim with one payment and remittance advice.

- The claim number for this second claim will be noted with an "M" after the original claim number in the Molina E-Portal. This claim will not be visible in the Molina E-Portal until the Medicare claim has processed.
- Reimbursement of a skilled nursing facility (SNF) stay will be the lesser of billed charges or the Medicare Resource Utilization Group (RUG) at the negotiated contract rate for each RUG:
- Day 1 – 20 Molina reimburses the lesser of billed charges or the full contracted amount for each Medicare RUG for a SNF stay.
- Days 21 – 100 Members receiving approved skilled services are reimbursed at the lesser of billed charges or the contracted amount for each Medicare RUG minus the member's prorated daily applied income as set by the HHSC Medicaid Eligibility Worker.
- Nursing Facilities must continue to collect Applied Income as designated by the HSS.
- Coinsurance will be paid from data received from the HHSC, therefore 3619's must be completed timely, or secondary payment will be delayed.

SNF Daily Rate Claims Filing Deadlines

Nursing Facility Providers must file SNF daily rate claims by the later of:

- 365 Days from date of service; OR
- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor

If the Nursing Facility Provider files a claim for a SNF stay with a third-party insurance resource, the wrong health plan, or with the wrong HHSC portal, and produces documentation verifying that the initial filing met the timeliness standard cited above, Molina will process the claim without denying the resubmission for failure to timely file. The NF Provider must file the claim by the later of:

- 365 Days from the date of service; OR
- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor

SNF stay claims not submitted with 365 days of the date of service or within 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor will be denied for failure to file timely.

Nursing Facility SNF Daily Rate Clean Claim Adjudication

Molina will Adjudicate SNF Daily Rate clean claims no later than 10 days after the submission to the Molina portal or HHSC's designated portal, whichever occurs first.

Appeal of Skilled Nursing Facility Daily Rate Claim

Nursing Facility is allowed 120 days from the date of the initial denial notification to submit an appeal. *See Chapter 7 Complaints and Appeals.*

MMP Nursing Facility Outpatient Services Claims (Part B services and supplies)

- MMP Outpatient services require Prior Authorization
- HCPCS codes used for Prior Authorization must match the codes submitted on the claim
- MMP Outpatient services claims must be filed separately from NF Daily Unit Rate, NF Add-on Services, Medicare Coinsurance and MMP SNF Daily Rate claims
- Claims must be filed electronically through the provider's clearing house or the Molina Provider Portal.
- MMP Outpatient services should follow the previously identified guidelines for professional claims.

MMP Outpatient Filing Deadlines

Nursing Facility Providers must file MMP Outpatient Service claims by the later of:

- 95 Days after the date of service; OR
- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor

If the Nursing Facility Provider files a claim for MMP Outpatient Services with a third party insurance resource, the wrong health plan, or with the wrong HHSC portal, and produces documentation verifying that the initial filing met the timeliness standard cited above, Molina will process the claim without denying the resubmission for failure to timely file. The NF Provider must file the claim by the later of:

- 95 Days after the date of service; OR
- 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor

Nursing Facility MMP Outpatient Services claims not submitted with 95 days of service or within 95 Days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor will be denied for failure to file timely.

MMP Nursing Facility Outpatient Clean Claim Adjudication

Molina will Adjudicate SNF Daily Rate clean claims no later than 30 days after the submission to the Molina portal or HHSC's designated portal, whichever occurs first.

Appeal of MMP Nursing Facility Outpatient Claim

Nursing Facility is allowed 120 days from the date of the initial denial notification to submit an appeal. *See Chapter 7 Complaints and Appeals.*

Acute Care Services Claims

Providers of all other acute care services are to follow guidelines as outlined in the Molina STAR/STAR+PLUS/CHIP&CHIP Perinate/Molina Dual Options(MMP) Provider Manual available at: www.Molinahealthcare.com

Auto-Adjusted Claims

Molina will make auto-adjustments to previously adjudicated claims within 30 days from the date of receipt of an adjustment from HHSC to reflect changes to such things as:

- Nursing Facility Daily Rate
- Provider Contracts
- Service Authorizations
- Applied Income
- Level of Service (RUG)

Adjustments to the Nursing Facility Unit Rate and other Medicaid or MMP services claims will process routinely without additional action required by the Nursing Facility. Generally, adjustment will occur simultaneously, with recoupment and/or payment in one transaction.

Corrected Claims Requirements

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P. **Claims submitted without the correct coding will be returned to the Provider for resubmission.**

Clean Claim Penalty Interest

Molina shall pay Nursing Facility Providers interest at a rate of 1.5% per month (18% per annum) on all clean claims that are not paid within 10 days (Nursing Facility Unit Rate, NF Medicare Coinsurance, MMP SNF) and 30 days (Nursing Facility Add-on Services, MMP Outpatient Services) respectively Claims that do not meet the requirements of a clean claim will still be paid or denied in a timely manner where possible, but Molina will not be

liable for any late-payment penalties on claims that do not meet the requirements of a clean claim.

Out of Network Provider Requirements

Out of Network Providers must follow the same standard claims submission practices as Network Providers. Out of Network Providers must file claims for all services within the same guidelines as Network Providers Out of Network Providers may be paid at 95% of the rate of a Network Provider.

Emergency Services Claims

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

Claim Codes

Providers must use good faith effort to bill Molina Healthcare for services with the most current coding (ICD-9, CPT, HCPCS etc.) available. These current claims, coding and processing guidelines will be available upon request to contracted, Molina network providers. The following information must be included on every claim:

A. Member name, date of birth and ID number
B. Date(s) of service
C. ICD-9 diagnosis and procedure codes
D. Revenue, CPT or HCPCS code for service or item provided
E. Billed charges for service provided
F. Place and type of service code
G. Days or units, as applicable
H. Provider tax identification and NPI number
I. Provider name and address

Claims Review and Audit

Provider acknowledges Molina'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 Uniform Billing manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices.

Provider acknowledges Molina's right to conduct such review and audit on a line-by-line basis and Molina's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Molina's right to conduct

utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider shall cooperate with Molina's audits of claims and payments by providing access to requested claim information, all supporting medical records, Provider's charging policies, and other related data. Molina shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding and payment.

Partially Payable Claims

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

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

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

Claims Questions, Re-Consideration and Appeals

Additional details regarding the process and timelines to appeal claim payments can be found in the "Complaints and Appeals" Chapter of this manual. If a provider has a question or is not satisfied with the information or payment they have received related to a claim, they should contact their assigned NF PSR or email NFProviderServices@Molinahealthcare.com or call Customer Services at 1-866-449-6849.

Chapter 11 – Authorization and Utilization

Healthcare Services

Molina provides care management services to Members using processes designed to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Molina utilizes an integrated case management model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk members supports better health outcomes. Elements of the Molina utilization management program include Pre-service review and Organization Determination/Authorization management that includes pre-admission, admission and inpatient review, Medically Necessary review, and restrictions on the use of non-network Providers. You can contact the Molina Utilization Department at (855) 322-4080.

Utilization Management (UM)

Molina's UM program ensures appropriate and effective utilization of services. The UM team works closely with the Case Management (CM) team to ensure Members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. To reflect the vital role this process plays in Molina's innovative HCS program, the UM program ensures the service delivered is Medically Necessary and demonstrates an appropriate use of resources based on the levels of care needed for a Member. This program promotes the provision of quality, cost-effective and medically appropriate services that are offered across a continuum of care, integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes as necessary and is designed to influence Member's care by:

- Identifying medical necessity and appropriateness while managing benefits effectively and efficiently to ensure efficiency of the health care services across the continuum of care;
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs;
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization while monitoring utilization practice patterns of Providers, hospitals and ancillary Providers to identify over and under service utilization;
- Implementing comprehensive processes to monitor and control the utilization of health care resources;
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness;
- Reviewing processes to ensure care is safe and accessible;

- Ensuring that qualified health care professionals perform all components of the UM/CM processes while ensuring timely responses to Member appeals and grievances;
- Ensuring that UM decision tools are appropriately applied in determining Medical Necessity decisions.
- Identifying and assess the need for Case Management/Health Management through early identification of high or low service utilization and high cost, chronic or long-term diseases;
- Promoting health care in accordance with local, state and national standards;
- Identifying events and patterns of care in which outcomes may be improved through efficiencies in UM, and to implement actions that improve performance by ensuring care is safe and accessible;
- Continually seeking to improve Member and Provider satisfaction with health care and with Molina utilization processes while ensuring that UM decision tools are appropriately applied in determining medical necessity decisions; and,
- Processing authorization requests timely with adherence to all regulatory and accreditation timeliness standards.

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

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

This Molina Provider Manual contains excerpts from Molina's Healthcare Services Program Description. For a complete copy of your state's Healthcare Services Program Description you can access the Molina website at www.MolinaHealthcare.com or contact the telephone number above to receive a written copy. You can always find more information about Molina's UM 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's UM Department is designed to provide comprehensive healthcare management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service. Molina works in partnership with Members and Providers to promote a seamless delivery of healthcare services. Molina's 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. Molina maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina medical management program also ensures that Molina only reimburses for services identified as a covered benefit and medically necessary. Elements of the Molina medical management program include medical necessity review, prior authorization, inpatient management and restrictions on the use of non-network Providers.

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

Medical Necessity Review

Molina only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to, MCG (formerly known as Milliman Care Guidelines), McKesson InterQual®, other-third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively.

Clinical Information

Molina requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina does not accept

clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulation or the Molina Hospital or Provider Services Agreement require such documentation.

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

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

The Utilization Management Department adheres to the HHSC and TDI approved standards for processing referrals, providing authorizations or denial decisions and the notification time frames.

These standards are applied to urgent or routine requests for prospective, concurrent and retrospective service. Practitioners/Providers and members may obtain urgent services twenty-four (24) hours a day, seven (7) days a week. Molina Healthcare maintains a toll-free (800) number that is staffed by Telephone Advice Nurses to assist in obtaining services. UM Staff is available eight hours a day during normal business hours for calls regarding UM issues. Staff can receive inbound communication regarding UM issues after normal business hours. Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon. Staff member identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. The toll-free number to reach UM staff for any/all inquiries or questions regarding the UM process is (866) 449-6849 and you will be prompted to the UM department.

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

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

Prior Authorizations – STAR+PLUS and MMP Services

The most common Prior Authorization Requests for Nursing Facilities:

- STAR+PLUS Add-On Services – PT/OT/ST

- MMP Skilled Nursing Facility (SNF) Services (Medicare Part A)
- MMP Outpatient Therapy Services (Part B)

STAR+PLUS and MMP NF Members may require additional covered STAR+PLUS Add-On Services or MMP covered serviced by other service type providers. It is the responsibility of the service provider to obtain the prior authorization but may require a co-operative effort between the NF and the service provider.

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

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

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

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

a. Member demographic information (Name, DOB, ID #, etc.).
b. Clinical information sufficient to document the Medical Necessity of the requested services
c. Provider demographic information (Referring provider and referred to Provider/facility).
d. Requested service/procedure (including specific CPT/HCPCS and ICD-10 Codes).
e. Location where the service will be performed.
f. Member diagnosis (CMS-approved diagnostic and procedure code and descriptions).
g. Pertinent medical history (include treatment, diagnostic tests, examination data).
h. Requested length of stay (for inpatient requests).
i. Indicate if request is for expedited or standard processing.

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

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the member's clinical situation. For expedited requests for authorization, we make a determination promptly as the member's health requires and no later than seventy-two (72) hours after we receive the initial request for service in the event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a member's life or health. For a standard authorization request, Molina makes the determination and provides feedback within three (3) business days for Medicaid and MMP.

Providers who request prior authorization for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss Medical Necessity decisions with the requesting Provider at (855) 322-4080.

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

How to Request an Authorization

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

Web Portal: Participating Providers are encouraged to use the Molina Web Portal for prior authorization submission. Instructions for how to submit a Prior Authorization Request are available on the Portal. The benefits of submitting your prior authorization request through the Provider portal are:

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

The Service Request / Authorization page has 4 functionalities:

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

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

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

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

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

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

Authorization Type	Fax Number
Prior Authorizations • Medicaid/CHIP • Nursing Facilities (Medicaid/CHIP/MMP) • MMP • LTSS	 (866) 420-3639 (844) 420-3639 (844) 251-1451 (844) 304-7127
Radiology Authorizations	(877) 731-7218
NICU Authorizations	(877) 731-7218
Pharmacy Authorizations • Medicaid/CHIP • MMP • MMP J Code Requests	 (888) 487-9251 (866) 290-1309 (844) 251-1451
Behavioral Health Authorizations	(866) 617-4967
Transplant Authorizations	(877) 813-1206

If the request is not on the form provided by Molina, be sure to send to the attention of the Healthcare Services Department. Please indicate on the fax if the request is urgent or non-urgent. **The Definition of expedited/urgent is when the situation where the standard time frame or decision-making process could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function**. Please include the

supporting documentation needed for Molina to make a determination along with the request to facilitate your request being made as expeditiously as possible.

Phone: Prior Authorizations can be initiated by contacting Molina's UM Department at **(855) 322-4080.** It may be necessary to submit additional documentation before the authorization can be processed.

Mail: Prior Authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:

Molina Healthcare of Texas
Attn: Healthcare Services Dept.
1660 N. Westridge Circle
Irving, TX 75038

PA Not Required

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

Authorization Turn-Around Times

TYPE OF REQUEST	HHSC – STAR, STAR+PLUS	MMP
Non-urgent pre-service decisions	Within 3 business days after receipt of request	Within 3 business days after receipt of request
Urgent pre-service	Within 72 clock hours of receipt of request	Within 1 business day of receipt of request

Post-stabilization care subsequent to emergency room treatment	Will provide the notice to the treating physician or other health care provider within the time appropriate to the circumstances **not later than one hour after the time of the request**; when denying post-stabilization care requests or life- threatening conditions requests by a treating physician or other health care provider.	Will provide the notice to the treating physician or other healthcare provider within the time appropriate to the circumstances, not later than one hour after the time of the request for life threatening/ post-stabilization.
Urgent concurrent review (i.e. inpatient, ongoing ambulatory services)	Within 24 clock hours of receipt of request.	Within the NCQA Standard of 24 Clock hours of the receipt of the request
Post-service decisions	30 calendar days (for par providers notification timelines should be reviewed prior to processing post service decisions unless EMTALA applies)	30 calendar days (For Par providers, notification timelines should be reviewed prior to processing post service decisions unless EMTALA applies)

Definitions:

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

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

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

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

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

Hospitals

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

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

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

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

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

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

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 durable medical equipment (DME) and Out-of-Area/Out-of-Network Professional Services. The pre-service review process assures the following:

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

Inpatient Review

Molina performs concurrent inpatient review in order to ensure patient safety, Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates may result in denial authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an inpatient, for those stays where there is a clear expectation, and the medical record supports that reasonable expectation of an extended stay, or where observation has been tried, in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed.

Inpatient Status Determinations

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

coding and Medical Necessity requirements. To determine Medical Necessity, the criteria outlined under “Medical Necessity Review” will be used.

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. Upon discharge the Provider must provide Molina with Member demographic information, date of discharge, discharge plan and disposition.

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

Post-Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina for services that require authorization. Failure to obtain authorization for an elective service that requires authorization will result in an administrative denial. Emergent services do not require authorization. Coverage of emergent services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied.

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Molina Member or there was a Molina error, a medical necessity review will be performed. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, Local and National Coverage Determinations, regulation and guidance and evidence-based criteria sets. Specific Federal requirements or Provider contracts that prohibit administrative denials supersede this policy.

Out-of-Network Providers and Services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Members. Molina requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide

Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations.

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

Avoiding conflict of Interest

The HCS Department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage. Molina does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. Molina also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Notification of Denied Services

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

Coordination of Care and Services

Molina staff work with Providers to assist with coordinating services and benefits for Members with complex needs. It is the responsibility of contracted Providers to assess Members and with the participation of the Member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

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

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

Continuity of Care and Transition of Members

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

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to ninety (90) days or longer if necessary for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary for a safe transfer.
- Exhibit pre-existing conditions
- Receiving care for a life-threatening illness, and
- Receiving care for a disability
- Currently hospitalized
- Transferring between facilities

Standard Continuity of Care requirements will remain in place for Acute Care services for 90 days and Long-Term Care Services and Supports (LTSS) for up to 6 months or until a new assessment is completed and new authorizations issued.

If a member moves out of the Molina Service Deliver Area, Molina will continue to cover medically necessary care through network and non-network providers until such time as the member can be transitioned to a MCO providing services in the new SDA.

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

For additional information regarding continuity of care and transition of Members, please contact Molina at (855) 322-4080.

Affirmative Statement about Incentives

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

Furthermore, Molina 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 or the delegated group. Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care. It is important to remember that:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care.
- UM decision makers do not receive incentives to encourage decisions that result in underutilization.

UM Decisions (MMP Only)

Written Notification of Denial – The Member must be provided with written notice of the determination, if the decision is to deny, in whole or in part, the requested service or payment. If the Member has an authorized representative, the representative must be sent a copy of the denial notice. The appropriate written notice, that has CMS approval, must be issued within established regulatory and certification timelines. The adverse organization determination 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 an appeal on the Member's behalf;
- Include a description of both the standard and expedited reconsideration process, timeframes and conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;

- Payment denials shall include a description of the standard reconsideration process, timeframes and other elements of the appeal process; and
- A statement disclosing the Member's right to submit additional evidence in writing or in person.
- Failure to provide the Member with timely notice of an organization determination constitutes an adverse organization determination which may be appealed.

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 or the delegated Medical Group/IPA must coordinate with the SNF, HHA or CORF Provider to ensure timely delivery of the written notice, using the approved NOMNC. 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; and
- If home health services are provided for a period of time exceeding two (2) days, the NOMNC must be provided on or before the second to last service date.

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

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

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

- Facts specific to the Member and relevant to the coverage determination that is sufficient to advise the Member of the applicability of the coverage rule or policy to the Member's case

Chapter 12 – Managed Care Member Enrollment and Disenrollment

Enrollment in Medicaid Programs

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

STAR+PLUS Member Enrollment & Span of Coverage

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

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

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

Health Plan Changes

<u>Member initiated change</u>

Members can change health plans by calling the: STAR + PLUS Help Line at 1-800-964-2777.

However, a member cannot change from one health plan to another health plan during an inpatient hospital stay.

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

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

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

Health Plan Initiated Change (Disenrollment):

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

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

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation, including medical documentation form the member's PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollemtn, is sent to HHSC, the final decision will be made by HHSC. Molina must notify the Member of Molina's decision to disenroll the Member if all reasonable measures have failed to remedy the problem. If the Member disagrees with the decision to disenroll the Member from Molina, Molina must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's State Fair Hearing process.

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

Disenrollment Request by Member

If a Member makes a request for disenrollment, Molina must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process. A disenrollment request will require medical documentation from the Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment. HHSC will make the final decision.

Automatic Disenrollment/Re-enrollment

When a member no longer meets the criteria for Managed Care enrollment, HHSC will automatically dis-enroll the member. The disenrollment will be effective the first of the following month in which MCO eligibility changes.

Examples for loss of Medicaid Managed Care eligibility are:

- The Member is over resourced to qualify for nursing facility services;
- The Member qualifies for HHSC hospice services
- The Member begins Medicare coverage
- The Member has left the service area Molina is contracted to provide MCO coverage in

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

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

Molina Dual Options STAR+PLUS MMP

All enrollment and disenrollment transactions, including enrollments from one STAR+PLUS MMP to a different MMP, will be processed through the Texas enrollment broker except those transactions related to non-Demonstration plans participating in Medicare Advantage. HHSC or its enrollment broker provides Medicaid-Medicare Enrollees with independent enrollment

assistance and options counseling to help them make an enrollment decision that best meets their needs.

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

Effective Date of Coverage

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

Disenrollment

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

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

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

- Out-of-area notification will be received from HHSC and forwarded to CMS on the monthly enrollment report;
- Through the CMS DTRR file (confirms that the enrollee has disenrolled)
- The enrollee may call to advise Molina that they have relocated, and Molina will direct them to HHSC for formal notification; and/or
- Other means of notification may be made through the Claims Department, if out-of-area claims are received with a residential address other than the one on file; Molina will inform HHSC so they can reach out to the enrollee directly to begin the disenrollment

process. (Molina's Dual Option STAR+PLUS MMP does not offer a visitor/traveler program to enrollees).

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

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

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

- Enrollee abuses the enrollment card by allowing others to use it to fraudulently obtain services;
- Enrollee leaves the service area and directly notifies Molina of the permanent change of residence;
- Enrollee has not permanently moved but has been out of the service area for six (6) months or more;
- Enrollee loses entitlement to Medicare Part A or Part B benefits;
- Enrollee loses Medicaid eligibility;
- Molina's Dual Option STAR+PLUS MMP loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina's Dual Option STAR+PLUS MMP will

  send CMS approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely, before the termination of the plan; and/or
- Molina's Dual Option STAR+PLUS MMP discontinues offering services in a specific service are where the enrollee resides.

In all circumstances, except death, (where HHSC delegates) Molina will provide a written notice to the enrollee with an explanation of the reason for the disenrollment; otherwise HHSC (or its designated enrollment broker) will provide a written notice. All notices will be in compliance with CMS regulations and will be approved by CMS. Each notice will include the process for filing a grievance.

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

<u>Inpatient at time of Enrollment</u>

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

Chapter 13 – Special Access Requirements

Interpreter/Translation Services

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

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

In addition, Members are advised in their welcome packet regarding interpretive and translation services and how to access the AT&T Language Line or the TTY line for Members who are hard of hearing or speech impaired. Molina's language assistance offers members the opportunity to discuss utilization management issues as well.

Molina/Provider Coordination

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

Molina's care coordination program is designed to identify potential clinical problems, especially those of a chronic or complex nature, engage the Member and PCP in determining a

care plan, providing ongoing case management support and care coordination, tracking and reporting efforts, adjusting staff levels as needed and monitoring the program for outcomes.

Once a plan of care is developed, case managers authorize all needed services, including those to specialists (in or out of network). If the specialist will be delivering care on an on-going basis, a standing referral will be established. At the Member's discretion and with the specialist's permission, the specialist may be designated as the Member's PCP.

Reading/Grade Level Consideration

Member materials are written at a 6th grade reading level or lower. The only exception to this is for medical or legal terminology.

Cultural Sensitivity

Molina responds to the cultural, racial, and linguistic needs (including interpretive service as necessary) of the Medicaid population. Molina is backed by an organization that has focused on serving low-income families and individuals for the past 24 years, providing a wealth of experience in meeting the diverse needs of the Medicaid population. This experience provides Molina access to the experience, resources, and programs designed to meet the unique healthcare needs of a culturally diverse membership. In demonstration of Molina's commitment to meeting the needs of a culturally diverse membership, cultural advisory committees have been established and are supported by one full-time cultural anthropologist who routinely advises Molina staff and committees about the differing needs.

It is Molina's intention to mail provider material that is culturally and linguistically appropriate for use by providers and members. In addition, interpretation services will be available and in-service trainings and discussions will be encouraged on these topics.

All provider promotional, educational, training, or outreach material will include an inventory control number per the requirements of HHSC.

Members with Special Needs (STAR+PLUS)

Overview

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

Molina will use Health Risk Coordinators (HRC) familiar with health assessment screening tools and application to work with those new Members who require special needs if identified as meeting Molina's assessment criteria for MSHCN. HRC professionals will coordinate their activities with the Quality Improvement/Utilization Management Department. Members identified with a special health care need will be referred to their PCP.

Molina will assign a Case Manager to work with the PCP to establish a plan of care, to assist the PCP with necessary referrals (if needed by the PCP), and to aid the Member in accessing the services, including any out-of-network referrals, standing referrals, transportation or translation/interpretation services needed.

Chapter 14 – Quality Management

Molina Healthcare has a comprehensive quality assurance program and will audit and review contracted providers upon its discretion. Providers have the responsibility to report any member fraud, waste, or abuse. Members also have the responsibility to report any provider fraud or abuse via the protocol listed in your provider manual.

The Quality Improvement Program (QIP) is established to provide the structure and key processes that enable the health plan to carry out its commitment to ongoing improvement of care and services, and improvement of the health of its members. The QIP assists Molina Healthcare to achieve these goals. It is an evolving program that is responsive to the changing needs of the health plan's customers and the standards established by the medical community, regulatory and accrediting bodies.

The QIP encompasses the quality of acute, chronic and preventive health care and service provided in both the inpatient and outpatient setting to our population as determined by age, disease categories, risk status and products. Molina Healthcare maintains the following values, assumptions, and operating principles for the Quality Improvement Program:

- The QIP provides a structure for promoting and achieving excellence in all areas through continuous improvement.
- Improvements are based on industry "best practice" or on standards set by regulators or accrediting organizations.
- The QIP is applicable to all disciplines comprising the health plan, at all levels of the organization.
- Teams and teamwork are essential to the improvement of care and services.
- Data collection and analysis is critical to problem-solving and process improvement.
- Each employee is highly valued as a contributor to quality processes and outcomes.
- Compliance with National Committee for Quality Assurance (NCQA) Standards and achievement of accreditation demonstrates Molina Healthcare's commitment to quality improvement.
- Information about the QIP is available for members and providers upon request.

Focus Studies, Utilization Management and Practice Guidelines

The QIP establishes and maintains focused review and clinical study processes to monitor, review, measure, track/trend and provide for the development and implementation of corrective action plans for specifically identified practitioners, processes, illnesses, diagnostic treatments, and meaningful clinical issues.

The Utilization Management Department submits quarterly reports to the Medical Advisory Committee (MAC) subcommittee of the Quality Improvement Committee. The MAC reviews

utilization trends in the areas of emergency room, NF Add-on services, Acute care services, inpatient, outpatient and top diagnoses and identifies opportunities for improvement. Clinical Practice Guidelines are reviewed and updated annually using evidence-based criteria. The updated guidelines are approved by the MAC annually and distributed to providers.

Using Performance Data

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

Chapter 15 – Fraud Information

Reporting Waste, Abuse, or Fraud by a Provider or Client (Medicaid Managed Care and MMP)

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid.
- Using someone else's Medicaid.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/
  Under the box labeled "I WANT TO" click: "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:
  Molina Healthcare of Texas Attn: Director of Compliance
  1660 N Westridge Circle
  Irving, TX 75038
  1-888-562-5442

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:

- The person’s name
- The person’s date of birth, Social Security number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse, or fraud

Chapter 16 – Contracting, Credentialing and Incentive Programs

Nursing Facility and Skilled Nursing Facility Contracting

Nursing Facilities and Skilled Nursing Facilities desiring to be a network provider of STAR+PLUS services to Molina members are required to execute a Nursing Facility Provider Agreement (NFPA) and meet the credentialing and minimum performance standards as set by HHSC.

Nursing Facilities and Skilled Nursing Facilities desiring to be a network provider of MMP, Medicare Options and Marketplace services to Molina members are required to execute a Hospital Services Agreement (HSA) and meet the Molina credentialing standards.

Any change in ownership (CHOW) of the NF/SNF requires a new contract(s) to be executed and the new ownership to meet the credentialing and minimum performance standards as set by HHSC. NFPA's and HSA's are NOT transferable to new ownership.

To request a NFPA and/or HSA email: MHTNursingFacility@Molinahealthcare.com

Credentialing

Effective April 1, 2019 Nursing Facilities are required to be credentialed per HHSC requirement to be a network provider. Nursing Facilities are required to re-credential every three years.
Any change of ownership (CHOW) requires initial credentialing to be completed. Credentialing status is not transferable to the new ownership.

The purpose of the Credentialing Program is to assure the Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee of Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of Providers for participation in the Molina network. This policy defines the criteria that are applied to applicants for initial participation, re-credentialing and ongoing participation in the Molina network. To remain eligible for participation Providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Providers who do not meet the criteria. Molina may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any Provider to a hearing or any other rights of review.

Providers must meet the following criteria to be eligible to participate in the Molina network. If the Provider fails to meet/provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

- **Application** - Provider must submit to Molina a complete credentialing application and signed attestation within 180 days. Application must include all required attachments.
- **NF License -** Provider must hold a valid Texas NF license
- **NF has a Medicare or Medicaid Certification**
- **NPI -** Provider must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).
- **Clinical Laboratory Improvement Amendment Certificate of Waiver (CLIA Waiver)** – If the NF/SNF is undergoing of change of ownership (CHOW), the NF must submit the CLIA Waiver within 84 calendar days from the submission of the application for credentialing.
- **NF is not listed on the following websites an excluded from participation in any federal or state health care program**
- **HHSC – OIG exclusions, and**
- **HHSC-OIG Exclusion Search**
- **NF's enrollment has not been terminated or its Medicaid provider contract cancelled by the HHSC-OIG**
- **Professional Liability Insurance (only applicable with HSA) –** Provider must supply current professional malpractice liability insurance coverage on application or current copy of certificate. Provider must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the provider's activities on Molina's behalf.

Burden of Proof

The Provider shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina network. This includes but is not limited to proper evaluation of their 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 network. If the Provider fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Providers who fail to provide this burden of proof do not have the right to submit an appeal.

Provider Termination and Reinstatement

If a Provider's contract is terminated and later it is determined to reinstate the Provider, the Provider must be initially credentialed prior to reinstatement, if there is a break in service more than thirty (30) calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Professional Review Committee's review must be re-verified. The Professional Review Committee or medical director, as appropriate, must review all credentials and make a final determination prior to the Provider's reentry into the network. Not all elements require re-verification; for example, graduation from medical school or residency completion does not change. If the contract termination was administrative only and not for cause, if the break in service is less than thirty (30) calendar days, the Provider can be reinstated without being initially credentialed.

If Molina is unable to recredential a Provider within thirty-six (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 sixty (60) calendar days of notice, when the Provider resumes practice, Molina will complete the recredentialing cycle. If either party terminates their contract and there was a break in service for more than thirty (30) calendar days, Molina will initially credential the Provider before the Provider rejoins the network.

Credentialing Application

At the time of initial credentialing and recredentialing, the Provider must complete a credentialing application designed to provide Molina with information necessary to perform a comprehensive review of the Provider's credentials. The application must be completed in its entirety. The Provider must attest that their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source.

Non-Discriminatory Credentialing and Recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) 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.

Notification of Discrepancies in Credentialing Information

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 sanctions. 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. Please also refer to the section below titled 'Providers Right to Correct Erroneous Information'.

Notification of Credentialing Decisions

A letter is sent to every Provider with notification of the Professional Review Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within two weeks of the decision. Copies of the letters are filed in the Provider's credentials files. Under no circumstance will notification letters be sent to the Providers later than sixty (60) calendar days from the decision.

Providers Rights during the Credentialing Process

Providers have the right to review their credentials file at any time. Provider's rights are published in the online Provider Manual for them to review at any time. Instructions for how to access the Provider Manual is also given to the Provider at the time of initial contracting. Providers are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

The Provider must notify the Credentialing Department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality 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.

Providers 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 or malpractice claims history. 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 ten (10) 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 is available.
- The Provider's response must be sent to Molina Healthcare, Inc. Attention: Credentialing Director at PO Box 2470, Spokane, WA 99210.

Upon receipt of notification from the Provider, Molina will document receipt of the information in the Provider's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Provider's credentials file. The Provider will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with Providers', 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 ten (10) calendar days, their application processing will be discontinued and network participation will be administratively denied or terminated.

Providers Right to be Informed of Application Status

Providers have a right, upon request, to be informed of the status of their application.
The Provider can request to be informed of the status of their application by telephone, email or mail. 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.

Excluded Providers

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

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

Ongoing Monitoring of Sanctions

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

- **The United States Department of Health & Human Services (HHSC), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusion Program –**
  and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions –** Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (for equivalent).
- **Medicare Exclusion Database (MED) –** Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **National Practitioner Database –** Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM) –** Monitor for Providers sanctioned with SAM.

Molina Quality Living Program (MQL)

The Molina Quality Living Program is offered to contracted Nursing Facilities. The purpose of the program is to reward and encourage quality and efficiency for Nursing Facilities that meet

or exceed specific performance criteria in the provision of custodial nursing care to Molina members.

The MQL Program offers Pay-for-Quality as well as other program benefits, such as quality of life activities for residents in MQL qualified facilities. The quality metrics are devised from the CMS 5 STAR rating program

Molina will monitor the CMS 5 STAR ratings quarterly via the CMS Nursing Home Compare website to determine eligibility and achievement in the MQL program. Pay-for-Quality will be calculated and paid on a quarterly basis.

The MQL Program and its eligibility requirements are subject to change or termination at the sole discretion of Molina.

NOTE: Providers are prohibited from influencing MCO selection.

The Molina Quality Living Program summary is available from the NF Provider Services Representative or request a copy via email: NFProviderServices@Molinahealthcare.com

Quality Incentive Payment Program (QIPP)

QIPP is a HHSC program to encourage nursing facilities to improve the quality and innovation of their services. Improvement is based upon several indices of success, including quality metrics that are collected by the Centers for Medicare & Medicaid Services (CMS)
QIPP eligibility, program design and calculation of payments are determined by HHSC. QIPP incentive payments are dependent upon HHSC funding. HHSC may terminate or modify the program at any time.

Molina will issue QIPP payments in accordance to the program design and as directed by HHSC.

For more information about QIPP please refer to the HHSC website:

https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes

Definitions

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Medicaid, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to Medicaid.

Adjudicate means to deny or pay a Clean Claim.

Agreement means this Nursing Facility Provider Agreement, together with all amendments, attachments, and incorporated documents or materials.

Applied Income means the portion of the earned and unearned income of the STAR+PLUS Member, or if applicable the Member and the Member's spouse, that is paid under the Medicaid program to an institution or long-term care facility in which the Member resides.

CFR means the Code of Federal Regulations.

Clean Claim means a claim submitted by a provider for health care services rendered to a Member with the data necessary for the MCO to adjudicate and accurately report the claim. For purposes of this Agreement, claims for Nursing Facility Unit Rate services that meet HHSC' criteria for clean claims submission are considered Clean Claims. Additional information regarding HHSC' criteria for clean claims submission is included HHSC's Uniform Managed Care Manual.

CMS means the Centers for Medicare and Medicaid Services.

Covered Services means health care services the MCO must arrange to provide Members, including all services required by the MCO's contracts with HHSC for STAR+PLUS and all value-added services offered by the MCO.

Day means calendar day unless otherwise specified.

DSHS means the Texas Department of State Health Services.

Dual Eligible means a Medicaid recipient who is also enrolled in Medicare.

Facility or Facilities means one or more licensed nursing facilities operated by the Provider and identified in Attachment A: Nursing Facility Demographic Information to this Agreement.

Form 3618 or Resident Transaction Notice means the form the Provider must use to inform the Health and Human Services Commission about transactions and changes (admissions or discharges) for Medicaid applicants and recipients in nursing facilities.

Form 3619 or Medicare/Skilled Nursing Facility Patient Transaction Notice means the form the Provider must use to inform the Health and Human Services Commission about transactions and changes (admissions or discharges) for Medicaid recipients or applicants approved by Medicare for a Medicare skilled nursing facility.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself, herself, or some other person. It includes any act that constitutes fraud under applicable federal or state law.

HHS means the U.S. Department of Health and Human Services.

HHSC means the Texas Health and Human Services Commission.

Managed Care Organization (MCO) means (collectively or individually, as appropriate in the context) MCO and its affiliates, except those specifically excluded by the MCO.

Medical Assistance Only (MAO) means a person that does not receive Supplemental Security Income benefits but qualifies financially and functionally for Medicaid assistance.

Medically Necessary has the meaning defined in 1 TAC § 353.2.

Member or Covered Person means an individual enrolled with the MCO and entitled to receive STAR+PLUS Covered Services.

Nursing Facility (also called nursing home or skilled nursing facility) means an entity or institution that provides organized and structured nursing care and services, and is subject to licensure under Texas Health and Safety Code, Chapter 242, as defined in 40 TAC § 19.101 and 1 TAC § 358.103.

Nursing Facility Add-on Services means the types of services that are provided in the Facility setting by the Provider or another network provider but are not included in the Nursing Facility Unit Rate, including but not limited to emergency dental services; physician-ordered rehabilitative services; customized power wheel chairs; and augmentative communication devices.

Nursing Facility Unit Rate means the types of services included in the HHSC daily rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The Nursing Facility Unit Rate also includes applicable nursing facility rate enhancements and professional and general

liability insurance. Nursing Facility Unit Rates exclude Nursing Facility Add-on Services.

OIG means the Office of Inspector General.

PASRR means the Preadmission Screening and Resident Review, a federally mandated program applied to all individuals seeking admission to a Medicaid-certified Nursing Facility. PASRR helps ensure that individuals are not inappropriately placed in nursing facilities for long-term care, and requires that all applicants to a Medicaid-certified nursing facility: (1) be evaluated for mental illness, intellectual disability, or both; (2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (3) receive the services they need in those settings.

Program means the terms of coverage under an applicable benefit contract for which Attachment B: Compensation Schedule is incorporated into this Agreement setting forth the Providers' reimbursement for a respective Program. Subject to the above sentence, "Program" may mean any Medicaid managed care program ("Medicaid") under which the MCO has authority to arrange for services for Covered Persons.

Provider Relations Specialist means a designated MCO representative who is proficient in Nursing Facility billing matters and able to resolve billing and payment inquiries.

Regulatory Requirements means all state and federal laws, rules, regulations, waivers, policies and guidelines, and court ordered consent decrees, settlement agreements, or other court orders .That apply to: this Agreement, MCO's managed care contract with HHSC, the STAR+PLUS
Program, nursing facility services, and all persons or entities receiving state and federal funds.

SAO means the Texas State Auditor's Office.

Service Coordinator means the MCO representative with primary responsibility for providing service coordination and care management to STAR+PLUS Program Members.

Significant Traditional Provider or STP means a nursing facility provider, identified by HHSC, who has provided a significant level of care to Medicaid clients.

Supplemental Security Income (SSI) means a Federal income supplement program funded by general tax revenues (not Social Security taxes) designed to help aged, blind and disabled people with little or no income by providing cash to meet basic needs for food, clothing and shelter.

STAR+PLUS or STAR+PLUS Program means the State of Texas Medicaid managed care program that provides and coordinates Covered Services for preventive, primary, acute and long-term services and supports, and nursing facility care, to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through the SSI program and/or the MAO

program. Children birth through age 20 who resides in nursing facilities will not participate in STAR+PLUS.

TAC means the Texas Administrative Code.

TDI means the Texas Department of Insurance.

UMCM means HHSC's Uniform Managed Care Manual, which is available on HHSC's website.

Waste means practices that are not cost-efficient