Provider Manual

Molina Healthcare of Illinois, Inc.

(Molina Healthcare or Molina)

Molina Marketplace 2022

MOLINA® HEALTHCARE

MolinaMarketplace.com

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

Last Updated: 07/2022

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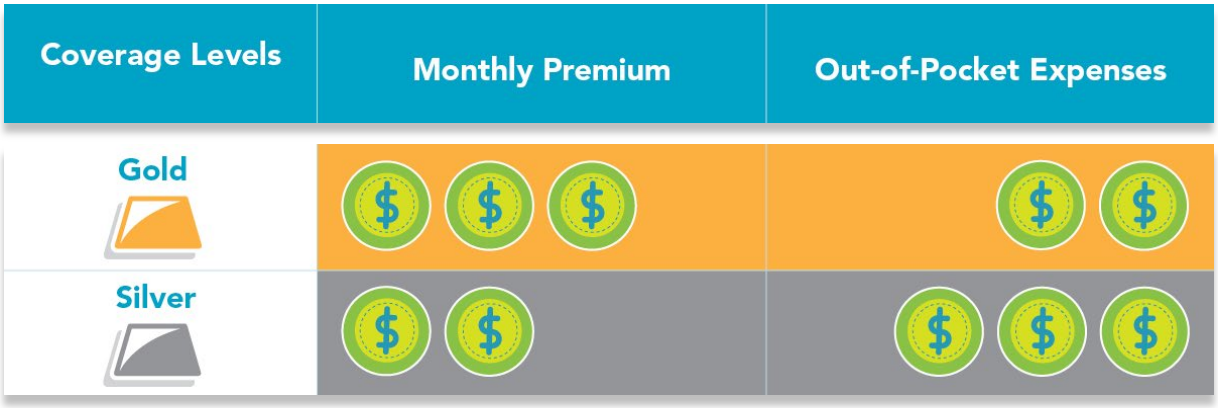
NOTE: See page 71 for critical update about Interoperability.

1. MARKETPLACE PRODUCTS

Molina Marketplace Plan Information

Molina offers two levels of affordable health plans for Members:

- Constant Care Silver™: Plans with lowest costs for doctor visits and urgent care.
- Confident Care Gold™: Plans with lower costs for expenses like doctor visits and out-of-pocket costs; generally higher premiums.



2. CONTACT INFORMATION

Molina Healthcare of Illinois, Inc.
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Provider Network Management Department

The Provider Network Management department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, Provider denied claims review, contracting, and training. The department has Provider Network Managers who serve all of Molina's Provider network. Eligibility verifications can be conducted at your convenience via the Molina Provider Portal.

Provider Email	Phone
MHILProviderNetworkManagement@MolinaHealthcare.com	(855) 866-5462

Member Services Department

The Member Services department handles all telephone and written inquiries regarding Member claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs) and Member complaints. Member Services representatives are available seven days a week, from 8 a.m. to 5 p.m., Central Time, excluding holidays. Eligibility verifications can be conducted at your convenience via the Provider Portal.

Phone	Hearing Impaired (TTY/TDD)
(855) 687-7861 (English & Spanish)	711

Claims Department

Molina strongly encourages Participating Providers to submit claims electronically (via a clearinghouse or the Provider Portal) whenever possible.

- Molina's Provider Portal: Molina Provider Portal
- Molina's EDI Payer ID: **20934**

To verify the status of your claims, please use the Provider Portal. For other claims questions, contact Provider Network Management.

Portal	Phone
Molina Provider Portal	(855) 866-5462

Claims Recovery Department

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

Address	Fax
Molina Healthcare of Illinois, Inc. Bin 88826 Milwaukee, WI 53288-0826	(855) 260-8740

Compliance and Fraud AlertLine

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

Phone	Website	Address
(866) 606-3889	MolinaHealthcare.alertline.com	Confidential Compliance Official Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802

Credentialing Department

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

Phone: (800) 423-9899
Fax: (800) 457-5213

Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Members. Members may call any time they are experiencing symptoms or need health care information. Registered nurses are available 24/7 year-round to assess symptoms and help make good health care decisions.

Nurse Advice Line (HEALTHLINE) 24 hours per day, 365 days per year	
English Phone - (833) 657-1982	**English TTY** – (888) 735-2929
Spanish Phone - (833) 657-1982	**Spanish TTY** – (888) 735-2929

Health Care Services Department

The Health Care Services (formerly Utilization Management) department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The Health Care Services (HCS) department also performs Care Management for Members who will benefit from such services. Participating Providers

are required to interact with Molina's HCS department electronically whenever possible. Prior Authorization/Service Requests and status checks can be easily managed electronically.

Managing Prior Authorizations/Service Requests electronically provides many benefits to providers, such as:

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

Molina offers the following electronic Prior Authorization/Service Request options:

- Submit requests directly to Molina via the Provider Portal. See the Provider Portal Quick Reference Guide, or contact your Provider Network Manager for registration and submission guidance.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Portal	UM and PA Fax
Molina Provider Portal	(833) 322-1061

Health Management Level 1 and Health Management Department

Molina's Health Management Level 1 (previously Health Education) and Health Management (previously Disease Management) Programs will be incorporated into the Member's treatment plan to address the Member's health care needs.

Phone	TTY/TDD
Member Services (855) 687-7861 (English & Spanish)	711

Behavioral Health

Molina manages all components of our covered services for Behavioral Health. For Member behavioral health needs, please contact Molina directly at (855) 687-7861. Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on the back of their Molina ID card.

Pharmacy Department

Prescription drugs are covered through CVS. A list of in-network pharmacies is available on the MolinaMarketplace.com website or by contacting Molina.

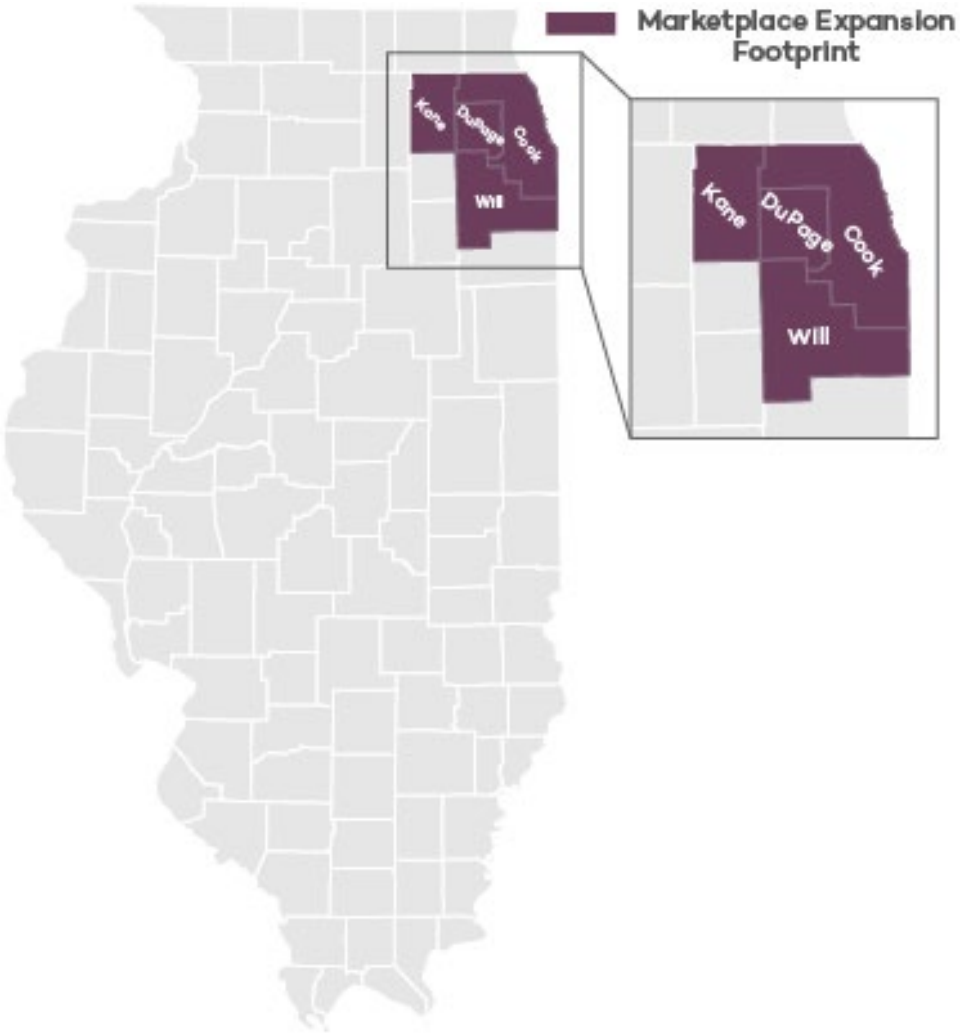
Phone	TTY/TDD
(855) 866-5462	711

Quality

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

Phone	Fax	Email
(855) 866-5462	(855) 556-2074	quality-healthcampaigns@molinahealthcare.com

Molina Healthcare of Illinois, Inc. Service Area



3. PROVIDER RESPONSIBILITIES

Nondiscrimination of Health Care Service Delivery

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

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

Section 1557 Investigations

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

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

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

Providers and Members seeking more information can refer to the Health and Human Services website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, Equipment, and Personnel

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

Provider Data Accuracy and Validation

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

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

Providers must validate the Provider Online Directory (POD) information **at least quarterly** for correctness and completeness. Providers must notify Molina in writing (some changes can be made online) as soon as possible, but no less 30 calendar days in advance of changes, such as but not limited to:

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

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

Please visit our Provider Online Directory (POD) at molina.sapphirethreesixtyfive.com to validate your information. For corrections and updates, a convenient Provider Information Update form can be found at molinamarketplace.com/marketplace/il/en-us/Providers/Provider-Forms. You can also notify your Provider Network Manager if your information needs to be updated or corrected.

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

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

National Plan and Provider Enumeration System Data Verification

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

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

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

Molina Electronic Solutions Participation

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

Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of Prior Authorization requests, Prior Authorization status inquiries, health plan access to Electronic Medical Records (EMR), electronic claims submission, Electronic Fund Transfers (EFT), Electronic Remittance Advice (ERA), electronic claims appeal, and registration for and use of the Provider Portal.

Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Provider Portal.

Any Provider entering the Network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Provider Portal within 30 days of entering the Molina Network.

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

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic claims submission options.
- Electronic payment: EFT with ERA.
- Provider Portal.

Electronic Claims Submission Requirement

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

- Promoting HIPAA compliance.
- Helping to reduce operational costs associated with paper claims (printing, postage, etc.).
- Increasing accuracy of data and efficient information delivery.
- Reducing claim processing delays, as errors can be corrected and resubmitted electronically.
- Eliminating mailing time and enabling claims to reach Molina faster.

Molina offers the following electronic claims submission options:

- Submit claims directly to Molina via the Provider Portal. See the Provider Portal Quick Reference Guide at molina.sapphirethreesixtyfive.com or contact your Provider Network Manager for registration and claim submission guidance.
- Submit claims to Molina through your EDI clearinghouse using **Payer ID 20934**, refer to our website MolinaMarketplace.com for additional information.

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

Provider Portal claims submission benefits to the Provider include:

- Adding attachments to claims.
- Submitting corrected claims.
- Easily and quickly voiding claims.
- Checking claims status.
- Receiving timely notification of a change in status for a particular claim.
- Saving incomplete/unsubmitted claims.
- Creating/managing claim templates.

For more information on EDI claims submission, see the claims and Compensation section of this Provider Manual.

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery processes.

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

Provider Portal

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

- Verify Member eligibility, covered services, and view HEDIS®-needed services (gaps).
- Claims:
  - Submit Professional (CMS-1500) and Institutional (UB-04) claims with attached files.

    - Correct/void claims.
    - Add attachments to previously submitted claims.
    - Check claims status.
    - Explanation of Payment (EOP).
    - Create and manage claims templates.
    - Create and submit a claim appeal with attached files.
- Prior Authorizations/Service Requests:
    - Create and submit Prior Authorization/Service Requests.
    - Check status of Authorization/Service Requests.
- View HEDIS® Scores and compare to national benchmarks.
- View a roster of assigned Molina members for PCPs.
- Download forms and documents.
- Send/receive secure messages to/from Molina.

Billing The Member

Covered Services

Molina Providers are prohibited from billing the member for any covered services except for copayments, coinsurance, and deductibles.

1. Copayments, coinsurance, and any unpaid portion of a deductible may be collected from the Member at the time of service.
2. If the amount collected from the Member is higher than the actual amount owed upon claim adjudication, the Provider must reimburse the Member the overpaid amount within 45 days.

For Members who are in a suspended status and seeking services from Providers:

1. Providers may advise the Member that services may not be delivered due to the fact that the Member is in a suspended status. (Status must be verified through Molina's Secure Provider Portal or by calling Provider Network Management. Providers should follow their internal policies and procedures regarding this situation.)

2. Should a Provider make the decision to render services, the Provider may collect from the Member. Providers must submit a claim to Molina.

3. If the Member subsequently pays his/her premium and is removed from a suspended status, claims will be adjudicated by Molina. The Provider would then be responsible for reconciling the payment received from the Member and the payment received from Molina. The Provider may then bill the Member for an underpayment or return to the Member any overpayment.

4. If the Member does not pay his/her premium and is terminated from the Molina plan, Providers may bill the Member for the full billed charges.

5. Non-participating Providers may be limited by state or other regulations when balance-billing Members for amounts not considered to be copayments, coinsurance, or deductible.

Non-Covered Services

Contracted Providers may only bill Molina Members for non-covered services if the Member and Provider both sign an agreement prior to the services being rendered outlining the Member's responsibility to pay.

The agreement must be specific to the services being rendered and clearly state:

1. The specific service(s) to be provided.
2. A statement that the service is not covered by Molina.
3. A statement that the Member chooses to receive and pay for the specific service.
4. Member is not obligated to pay for the service if it is later found that service was covered by Molina at the time it was provided, even if Molina did not pay the Provider for the service because the Provider did not comply with Molina requirements.

Billing for "No-Shows"

Providers may bill the Member a reasonable and customary fee for missing an appointment when the Member does not call in advance to cancel the appointment. The "no show" appointment must be documented in the medical record.

Premium Grace Period for Members With Advanced Premium Tax Credits (APTC)

For purposes of this discussion, please note the following:

1. Premiums are billed and paid at the subscriber level; therefore, the grace period is applied at the subscriber level.
2. All Members associated with the subscriber will inherit the enrollment status of the subscriber.
3. After the initial premium is paid, a grace period of three months from the premium due date is given for the payment of premium.
4. Coverage will remain in force during the grace period.
5. If payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period. The Member shall be held liable for the cost of Covered Services received during the grace period, as well as any unpaid premium.
6. During months two and three of the grace period, claims will be pended. The EX Code on the Explanation of Payment will state "LZ – Pend: Non-Payment of Premium." During month one, claims may be submitted and paid.

Failure to Obtain Authorization

Providers may not bill Members for services when the Provider fails to obtain an authorization and the claim is denied by Molina.

No Balance Billing

Payments made by Molina to providers, less any copays, coinsurance, or deductibles (which are the financial responsibility of the Member), will be considered payment in full.

Providers may not seek payment from Molina Members for the difference between the billed charges and the contracted rate paid by Molina.

Interim Billing

It is the policy of Molina Marketplace not to accept interim billing for estimated monies owed to participating and non-participating facilities. Claims processing will begin upon receipt of the final bill for services rendered for inpatient hospital stays and Skilled Nursing.

- Molina requires that participating and non-participating Providers submit final claim upon Member's discharge from facility.
- To facilitate claims processing, it is recommended that Providers include an itemized statement and any supporting documentation with the claim submission.
- Interim billing will not be accepted. The claim will be denied until the final claim for the inpatient hospital stay or Skilled Nursing from the first date of admission through the date of final discharge is received.

Member Rights and Responsibilities

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

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

Member Information and Marketing

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

Contact your Provider Network Manager for information and review of proposed materials.

Member Eligibility Verification

Possession of a Molina ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

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

- Provider Portal at availity.com/molinahealthcare.
- Molina Provider Services automated IVR system at (855) 866-5462.

For additional information refer to the Eligibility and Grace Period section of this Provider Manual.

Member Cost-Share

Under no circumstance will Members be liable for any amount owed by Molina to the Provider. Balance billing Molina Members for services covered by Molina is prohibited. This includes asking Members to pay the difference between the discounted and negotiated fees and the Provider's usual and customary fees. In addition, Providers are responsible for verifying eligibility and obtaining approval for services that require Prior Authorization.

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

Health Care Services (Utilization Management and Care Management)

Providers are required to participate in and comply with Molina's Utilization Management and Care Management programs, including all policies and procedures regarding Molina's facility admission, Prior Authorization, Medical Necessity review determination, and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

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

In-Office Laboratory Tests

Molina's policies allow only certain lab tests to be performed in a Provider's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full-service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing, and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found on the Molina website at MolinaMarketplace.com.

Additional information regarding in-network laboratory Providers and in-network laboratory Provider patient service centers is found on the laboratory Providers' respective websites at QuestDiagnostics.com and LabCorp.com.

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

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

Referrals

Molina has a procedure to process either a referral or a standing referral request from a Primary Care Provider (PCP), Women's Principal Health Care Provider (WPHCP), or Specialist to an in-network or out-of-network specialist.

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

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers that are contracted and credentialed (if applicable) with Molina. In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including but not limited to primary care, urgent care, and hospital Emergency Room. There may be circumstances in which referrals may require an out-of-network Provider. Prior Authorization from Molina will be required, except in the case of Emergency Services. For additional information, please refer to the Health Care Services section of this Provider Manual.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to Molina. Molina requires referring provider NPI and Taxonomy on claim submissions for specialist care. The following provider types are exempt from referring provider requirement:

- Primary Care Providers (PCP).
- Women's Principal Health Care Providers (WPHCP).
- Mental Health/Substance Use Providers.
- Emergent Care Provider.

Treatment Alternatives and Communication with Members

Molina endorses open Provider/Member communication regarding appropriate treatment alternatives and any follow-up care. Molina promotes open discussion between Providers and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Maternal Care

Molina requires that all contracted hospitals and birthing centers have policies in place that safely reduce C-sections and Early Elective Delivery (EED). Molina will enable Members to receive timely and evidence-based postpartum care. At a minimum, Molina shall provide and document the following services:

Postpartum visits, in accordance with the HFS' approved schedule, to assess and provide education on areas such as perineum care, breastfeeding/feeding practices, nutrition, exercise, immunization, sexual activity, effective family planning, pregnancy intervals, physical activity, SIDS, the importance of ongoing well-woman care, and referral to parenting classes, maternity education tools, platforms and materials, and Women, Infants, and Children (WIC).

Pharmacy Program

Providers are required to adhere to Molina's drug formularies and prescription policies.

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

Participation in Quality Programs

Providers are expected to participate in Molina's Quality Programs, and collaborate with Molina in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to care standards.
- Site and medical record-keeping practice reviews as applicable.
- Delivery of patient care information.

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

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member Protected Health Information (PHI).

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

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than 10 years, and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information, please refer to the Provider Disputes and Complaints, and Enrollee Appeal and Grievance Processes section of this Provider Manual.

Participation in Credentialing

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

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

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

Delegation

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

Primary Care Provider (PCP) Responsibilities

PCPs are responsible for:

- Serving as the ongoing source of primary and preventive care for Members.
- Assisting with coordination of care as appropriate for the Member's health care needs.
- Recommending referrals to specialists participating with Molina.
- Appropriate triage.
- Notifying Molina of Members who may benefit from Care Management.
- Participating in the development of Care Management treatment plans.

4. CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services (CLAS) in Health Care standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services.

Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA), and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability.

Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages, and religions, as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaMarketplace.com, from your Provider Network Manager, or by calling Molina's Provider Network Management department at **(855) 866-5462**.

Nondiscrimination of Health Care Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages.

All Providers who join the Molina Provider Network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS), the Office for Civil Rights (OCR), state law, and federal program rules which prohibit discrimination. Providers must post a nondiscrimination notification in a conspicuous location in their office along with translated non-English taglines in the top languages spoken in the state to ensure that Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred. For additional information, please refer to the Member Agreement and Combined Evidence of Coverage and Disclosure Form located at molinamarketplace.comhttps://www.molinamarketplace.com/marketplace/il/en-us/MemberForms.aspx/marketplace/il/en-us/MemberForms.aspx.

Additionally, Participating Providers or contracted medical groups/Independent Physician Associations (IPAs) may not limit their practices because of a Member's

medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

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

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

Members can mail their complaint to Molina:

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

Members can also file a civil rights complaint with HHS OCR. Complaint forms are available at hhs.gov/ocr/complaints/index.html. The form can be mailed to:

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

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

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

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

Cultural Competency

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

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and community-based organizations. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Network Management or with online training modules.

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

1. Provider-written communications and resource materials.

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

Integrated Quality Improvement—Ensuring Access

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

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

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

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity, and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
  - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (community health measures and state rankings report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS® Qualified Health Plan (QHP) Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at **(855) 687-7861**. If Contact Center

Representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified language service Provider.

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

Documentation

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

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

Members Who Are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to the Member and Provider Contact Center, Quality, Health Care Services, and all other health plan functions.

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

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center, Quality, Health Care Services, and all other health plan functions. Molina strongly recommends that Provider offices make assistive listening devices available for Members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

Nurse Advice Line

Molina provides 24/7 Nurse Advice Services for Members. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly: English **(888) 275-8750** or TTY/TDD 711, Spanish **(866) 648-3537**. The Nurse Advice Line telephone numbers are also printed on membership cards.

5. MEMBER RIGHTS AND RESPONSIBILITIES

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

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

For additional information, please contact Molina at **(855) 687-7861**, 8 a.m. to 5 p.m., Central Time, Monday through Friday, excluding state and federal holidays. TTY/TDD users, please call 711.

Second Opinions

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

6. ELIGIBILITY AND GRACE PERIOD

Eligibility Verification

Health Insurance Marketplace Programs

Payment for services rendered is based on enrollment status and coverage selected. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for Molina Marketplace Programs

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

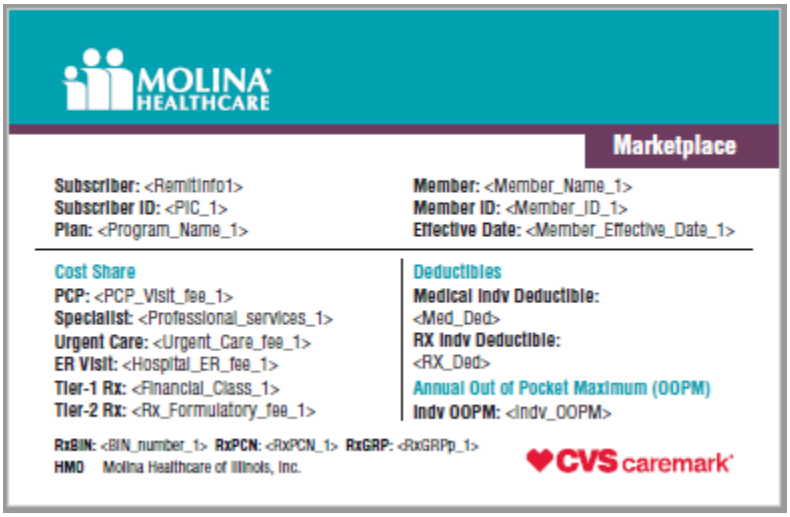
- Provider Portal at molina.sapphirethreesixtyfive.com.
- Molina Provider Network Management automated Interactive Voice Response (IVR) system at **(855) 687-7861**.

Possession of a Marketplace ID card does not automatically guarantee that the holder is eligible for Marketplace services. Providers should verify eligibility each time the patient presents to their office for services. The verification sources can be used to verify a patient's enrollment in a Molina Marketplace plan.

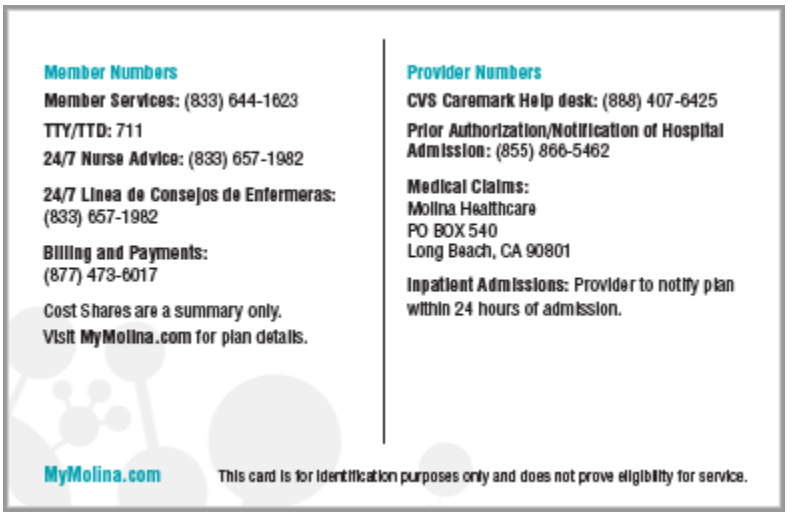
Identification Cards

Molina Healthcare of Illinois, Inc. Sample Member ID Card

Card Front



Card Back



Members are reminded in their agreement to present ID cards when requesting medical or pharmacy services. The Molina ID card can be a physical ID card or a digital ID card. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment prior to rendering services. Unless an Emergency Medical Condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Grace Period

Definitions

Advanced Premium Tax Credit (APTC): Goes toward your health insurance premium—what Members pay each month to maintain health coverage.

APTC Member: A Member who receives Advanced Premium Tax Credits (premium subsidy), which helps to offset the cost of monthly premiums for the Member.

APTC Member: A Member who receives federal Advanced Premium Tax Credits (premium subsidy), which helps to offset the cost of monthly premiums for the Member.

APA Member: A Member who receives Advanced Premium Assistance from the state, which helps to offset the cost of monthly premiums for the Member.

Non-APTC Member: A Member who is not receiving any Advanced Premium Tax Credits and is, therefore, solely responsible for the payment of the full monthly premium amount.

Non-Subsidy Member: A Member who is not receiving any Advanced Premium Tax Credits or advanced premium assistance from the state and is, therefore, solely responsible for the payment of the full monthly premium amount.

Member: An individual, including any dependents, enrolled in Molina Marketplace. This term includes APTC Members, APA Members, and Non-Subsidy APTC Members.

Summary

The Affordable Care Act mandates that all qualified health plans offering insurance through the Health Insurance Marketplace provide a grace period of three consecutive months to APTC Members who fail to pay their monthly premium by the due date. Molina Marketplace also offers a grace period in accordance with state law to:

- APA Members for three consecutive months.
- Non-Subsidy APTC Members (for a period of 31 days) who fail to pay their monthly premium by the due date.

To qualify for a grace period, the Member must have paid at least one full month's premium within the benefit year. The grace period begins on the first day of the first month for which the Member's premium has not been paid. The grace period is not a "rolling" period. Once the Member enters the grace period, he/she has until the end of that period to resolve the entire outstanding premium balance; partial payment will not extend the grace period.

Grace Period Timing

Non-Subsidy APTC Members

Non-Subsidy APTC Members are granted a 31-day grace period, during which they may be able to access all services covered under their benefit plan. If the full past-due premium is not paid by the end of the grace period, the Non-Subsidy APTC Member will be terminated as of the last day of the grace period: first day following the last month for which the premium was paid.

APTC and APA Members

Both APTC and APA Members are granted a three-month grace period. During the first month of the grace period, claims—including Pharmacy claims—and authorizations will continue to be processed. During the second and third months of the grace period, the Member's coverage will be suspended, and claims and authorizations will not be processed. If the Member's full past-due premium is not paid by the end of the third month of the grace period, the Member will be retroactively terminated as of the first last day of the second first month of the grace period.

Service Alerts

When a Member is in the grace period, Molina will include a service alert on the Provider Portal, Interactive Voice Response (IVR), and in the call centers. This alert will provide detailed information about the Member's grace period status, including which month of the grace period the Member is in (i.e., first month vs. second or third), as well as information about how authorizations and claims will be processed during this time. Providers should verify both the eligibility status and any service alerts when checking a Member's eligibility. For additional information about how authorizations and claims will be processed during this time, please refer to the Member's Evidence of Coverage, or contact Molina's Provider Network Management department at **(855) 866-5462**.

Provider and Member Notification

All Members will be notified upon entering the grace period. Additionally, when either an APTC or APA Member enters the grace period, his/her eligibility becomes available on the Provider Portal and should be checked prior to providing services. Additionally, Molina will notify Providers as follows:

- Members who receive APTC and have entered the first month of the grace period will not have any service restrictions. Therefore, the message that Providers will see upon checking the Provider Portal will read as follows: No Enrollment Restrictions.
- Providers will be notified and are able to check that the APTC Member entered the second or third months of the grace period.
- All Providers and, specifically, Providers who have submitted claims for the APTC Member in the two months prior to the start of the grace period will be notified and are able to check that the APTC Member entered the second or third months of the grace period.
- Providers will be notified and are able to check if the APTC Member is in the second or third months of the grace period before services are rendered and before submitting claims.
- The APTC/APA Member's assigned PCP, medical group, any provider with an outstanding authorization, and any provider who submitted claims for the Member in the two months prior to the start of the grace period will receive a "Notice of Suspension" stating that the Member has entered the three-month grace period.
- Providers who submit claims for services rendered during the grace period will receive notification that the APTC/APA Member is in the grace period.
- This notification will advise Providers that services rendered during the second and third months of the grace period may be denied if the premium is not paid in full prior to the expiration of the third month of the grace period.

The online eligibility notification will advise Providers that services rendered during the second and third months of the grace period may be denied if the premium is not paid in full prior to the expiration of the third month of the grace period.

Prior Authorizations

All authorization requests will be reviewed based on Medical Necessity and will expire after 30 days. If a request for a Prior Authorization is made, the Provider will receive the following disclaimer:

> "Prior Authorization is a review of Medical Necessity and is not a guarantee of payment for services. Payment will be made in accordance with a determination of the Member's eligibility on the date of service (for Molina Marketplace Members, this includes grace period status), benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable Provider agreement. If permitted under state law, Molina Healthcare will pend claims for services provided to Marketplace members in months 2 & 3 of the federally required grace period until such time as all outstanding premiums due are received or the grace period expires, whichever occurs first. For additional

information on a Marketplace member's grace period status, please contact Molina Healthcare."

Molina will pend claims for services provided to APTC/APA Members in months two and three of the federally or state-required three-month grace period until such time as all outstanding premiums due are received or the grace period expires, whichever occurs first. For additional information on a Marketplace Member's grace period status, please contact Molina.

APTC and APA Members

Authorization requests received during the first month of an APTC Member's three-month grace period will be processed according to Medical Necessity standards. Authorizations during the second and third month of the APTC Member's grace period will process in accordance with state and federal statutes and regulations, and according to Medical Necessity. Authorizations issued during this time will include notification that the APTC Member is in the second or third month of the grace period, and claims for the authorized services may be denied if the premium is not paid in full by the end of the grace period.

Authorization requests received during the first month of an APTC/APA Member's three-month grace period will be processed according to Medical Necessity standards. Authorizations received during the second and third month of the Member's grace period will be denied, due to the suspension of coverage. If the Member pays the full premium payment prior to the expiration of the three-month grace period resulting in the instatement of his/her coverage, Providers may then seek authorization for services. If the Member did not receive services during the second or third month of the grace period because the Prior Authorization was denied, the Provider must submit a new authorization request for those services. If the Member whose coverage has been reinstated received services during the second or third month of the grace period without a Prior Authorization, the Provider may request a retro-authorization for those services already rendered. All authorization requests will be reviewed based on Medical Necessity.

Non-Subsidy APTC Members

Authorization requests received during a non-subsidy APTC Member's 31-day grace period will be processed according to Medical Necessity standards.

Claims Processing

APTC and APA Members

First Month of Grace Period: Clean claims received for services rendered during the first month of a three-month grace period will be processed using Molina's standard processes and in accordance with state and federal statutes and regulations. and within established turnaround times.

Second/Third Month of Grace Period: Clean claims received for services rendered during the second and third months of an APTC/APA Member's three-month grace period will be pended until the premium is paid in full. In the event that the Member is

terminated for non-payment of the full premium prior to the end of the grace period, Molina will deny claims for services rendered in the second and third months of the grace period. Pharmacy claims will be processed based on program drug utilization review and formulary edits; the Member will be charged 100% of the discounted cost for prescriptions filled during the second and third months of the grace period.

Non-Subsidy APTC Members

Clean claims received for services rendered during the 31-day grace period will be processed using Molina's standard processes and in accordance with state and federal statutes and regulations and within established turn-around-times.

7. BENEFITS AND COVERED SERVICES

Molina covers the services described in the Summary of Benefits and Coverage and Schedule of Benefits documentation for each Molina Marketplace plan type. Questions regarding whether a service is covered or requires Prior Authorization can be answered using the Prior Authorization tools located on the Molina website and Provider Portal. You may also contact Molina at **(855) 866-5462** from 8 a.m. to 5 p.m., Central Time Monday through Friday, excluding state and federal holidays.

Verification of Benefits

Detailed information about benefits and services can be found in the Schedule of Benefits made available to Molina Marketplace Members via the Molina Member Portal. Providers can access Schedule of Benefits documents via the Provider Portal at molina.sapphirethreesixtyfive.com.

Member Cost Share

Cost share is the deductible, copayment, or coinsurance that Members must pay for Covered Services provided under their Molina Marketplace plan. The cost share amount Members are required to pay for each type of Covered Service is summarized on the Member's ID card. Additional detail regarding cost share is listed in the Schedule of Benefits. Cost share applies to all Covered Services except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act). Cost share toward Essential Health Benefits may be reduced or eliminated for certain eligible Members, as determined by Marketplace's rules.

A member pays the lesser of the cost sharing amount or billed charges.

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

Non-Formulary Drug Exception Request Process

Formulary exceptions include two types of requests:

- Standard Exception Request.
- Expedited Exception Request for urgent circumstances that may seriously jeopardize life, health, or ability to regain maximum function, or for undergoing current treatment using non-formulary drugs.

The Member and/or Member's representative and the prescribing Provider will be notified of Molina's decision no later than:

- 24 hours following receipt of request for Expedited Exception Request.
- 72 hours following receipt of request for Standard Exception Request.

If the initial request is denied, an external review may be requested. The Member and/or Member's representative and the prescribing Provider will be notified of the external review decision no later than:

- 24 hours following receipt of the request for external review of the Expedited Exception Request.
- 72 hours following receipt of the request for external review of the Standard Exception Request.

Injectable and Infusion Services

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

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

Emergency Mental Health or Substance Abuse Services

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

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

Out-of-Area Emergencies

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

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

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

Emergency Transportation

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

Non-Emergency Medical Transportation (NEMT)

Non-routine, non-Emergency Medically Necessary ground transportation is covered when Molina determines such transportation is needed within Molina's Service Area to transfer a Member from one medical facility to another. This includes NEMT from one hospital to another hospital, from a hospital to a skilled nursing facility or hospice. NEMT is provided by wheelchair-lift equipped vehicle, litter/stretcher van, or non-emergency ambulance (both advanced life support and basic life support). When NEMT is needed, Molina will arrange for the transportation to be provided by a Participating Provider transportation vendor. **Note**: This is not a service for which Members can self-refer, and any services not arranged by Molina will not be covered. To arrange for this service, call **(855) 866-5462** or fax **(833) 322-1061**.

Telehealth and Telemedicine Services

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

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

Upon at least 10 days' prior notice to Provider, Molina shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of Molina. Provider shall make its personnel reasonably available to answer questions from Molina regarding telehealth operations.

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

Preventive Care

Preventive Care Guidelines are located on the Molina website. The Preventive Health Guidelines page is under the Health Resources tab.

Nurse Advice Line

Members may call the Nurse Advice Line any time they are experiencing symptoms or need health care information. Registered nurses are available 24/7 year-round to assess symptoms and help the Member make good health care decisions.

Molina is committed to helping our Members:

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

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

8. HEALTH CARE SERVICES (HCS)

Introduction

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

Utilization Management (UM)

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

Molina maintains flexibility to adapt to changes in the Member's condition and is designed to influence the Member's care by:

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

Key Functions of the UM Program

All Prior Authorizations are based on a specific standardized list of services. The following table outlines the key functions of the UM Program.

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

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

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

UM Decisions

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

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

Molina follows a hierarchy of medical necessity decision-making, with federal and state regulations taking precedence. Molina covers all services and items required by state and federal regulations.

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

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

Providers can contact Molina's Health Care Services department at **(855) 866-5462** to obtain Molina's UM Criteria.

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

MCG for Cite Guideline Transparency

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

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

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

Medical Necessity

Medically Necessary or **Medical Necessity** means a service that is appropriate, no more restrictive than that used in the state Medicaid Program, including quantitative or non-quantitative treatment limits, as indicated in state statutes and regulations, the state Plan, and other state policies and procedures; also the service meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with contractor's guidelines, policies, or procedures for:

- The diagnosis or treatment of a covered illness or injury.
- The prevention of future disease.
- Assisting in the Enrollee's ability to attain, maintain, or regain functional capacity.
- An Enrollee to achieve age-appropriate growth and development.

This is to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms. Those services must be deemed by Molina to be:

- In accordance with generally accepted standards of medical practice.
- Clinically appropriate and clinically significant in terms of type, frequency, extent, site, and duration.

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

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

The fact that a Provider has prescribed, recommended, or approved medical or allied goods or services does not solely make such care, goods, or services Medically Necessary, a Medical Necessity, or a covered service/benefit. Prior Authorization determinations are made based on a review of Medical Necessity for the requested service.

Medical Necessity Review

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

Molina will not approve a Prior Authorization if information requested in connection with reviewing the Prior Authorization is not provided. If a service request is not Medically Necessary, it will not be approved. If the service requested is not a Covered Service, it will not be approved. Members will get written notification informing them why the Prior Authorization request was not approved. The Member, the Member's authorized representative, or their Provider may appeal the decision. The denial decision letter will inform the Member how to appeal. If a Member or their Provider decides to proceed with a service that has not been authorized by Molina, the Member will have to pay the cost of those services.

Levels of Administrative and Clinical Review

The Molina review process begins with administrative review followed by clinical review if appropriate.

Administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage. Clinical review includes Medical Necessity and level of care.

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

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

Clinical Information

Molina requires that copies of clinical information be submitted for documentation. Clinical information includes but is not limited to:

- Physician emergency department notes.
- Inpatient history/physical exams.
- Discharge summaries.
- Physician progress notes.
- Physician office notes.
- Physician orders.
- Nursing notes.
- Results of laboratory or imaging studies.
- Therapy evaluations.
- Therapist notes.

Molina does not accept clinical summaries, telephone summaries, or inpatient Case Manager criteria reviews as meeting the clinical information requirements unless state or federal regulations allows such documentation to be acceptable.

Prior Authorization

Molina requires Prior Authorization (PA) for specified services, providing 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 Current Procedural Terminology (CPT) and Health care Common Procedural Coding System (HCPCS) codes. Molina PA documents are normally updated quarterly but may be updated more frequently as appropriate. They are posted on the Forms & Documents page of the Molina website.

Providers are encouraged to use the Molina PA form housed on the Molina website. If using a different form, the Prior Authorization request **must** include the following:

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred-to Provider/facility).
- Address and NPI number of referring Provider and referred-to Provider/facility.
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.

- Clinical information that is sufficient to document the Medical Necessity of the requested service, including:
  - Pertinent medical history (include treatment, diagnostic tests, examination data).
  - Requested length of stay (for inpatient requests).
  - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by federal and state law) are excluded from the Prior Authorization requirements. Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices, and whether the service was provided in the most appropriate and cost-effective setting of care. Molina does not retroactively authorize services that require PA.

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is a situation where the standard time frame or decision-making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request, or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited organization determination/pre-service authorization request, Molina will make a determination as promptly as the Member's health requires, and no later than contractual requirements or 72 hours after receiving the initial request for service in the event a Provider indicates, or if we determine that a standard authorization decision time frame could jeopardize a Member's life or health. For a standard authorization request, Molina makes the determination and provides notification within five to 14 calendar days from receipt of all necessary information.

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has full-time Medical Directors available to discuss Medical Necessity decisions (peer-to-peer call) with the requesting Provider by contacting the Utilization Management department as indicated on the denial notification to schedule the call. Providers can also submit a request for "reconsideration" in place of a peer-to-peer call if significant information was left out of the original request.

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

Peer-to-Peer Review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five business days of the denied authorization request while the patient is inpatient, or within one business day of discharge. For inpatient admissions, a request for a peer-to-peer discussion may be granted within five business days from discharge.

A "peer" is considered a physician, physician assistant, nurse practitioner, or Ph.D. psychologist, or a Medical Director on site at the facility who is directly providing care to the Member. Contracted external parties, administrators, or facility UM staff are not peers, and calls will not be returned.

Requesting Prior Authorization

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

For additional information regarding the Prior Authorization of specialized clinical services, please refer to Molina's online Prior Authorization tools located on the MolinaMarketplace.com website.

- Prior Authorization Code LookUp Tool.
- Prior Authorization Code Matrix.
- Prior Authorization Pre-Service Review Guide.

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Molina website at MolinaMarketplace.com.

Provider Portal

Participating Providers are strongly encouraged to use the Provider Portal for Prior Authorization submissions whenever possible. Instructions for submitting a PA request are available on the Provider Portal after logging in. The benefits of submitting your PA request through the Provider Portal are:

- 24/7 year-round service.
- Create and submit Prior Authorization requests.
- Check status of Prior Authorization requests.
- Receive notification of change in status of Prior Authorization requests.
- Attach medical documentation required for timely medical review and decision-making.

Fax: The Prior Authorization Request form can be faxed to Molina at **(833) 322-1061**.

Phone: Prior Authorizations can be initiated in the Molina Provider Portal.

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

Open Communication About Treatment

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

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

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. They must have the ability to meet, perform the delegated activities, and maintain specific delegation criteria in compliance with all current Molina policies, and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation Section of this Provider Manual.

Communication and Availability to Members and Providers

HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff at **(855) 866-5462** during normal business hours, Monday through Friday (except for holidays) from 8 a.m. to 5 p.m. Central Time. All staff members identify themselves by providing their first name, job title, and organization.

Molina offers TTY/TDD services for Members who are deaf, hard of hearing, or speech impaired. Language assistance is also always available for Members.

After business hours, Providers can also use fax and the Provider Portal for UM access.

Molina's Nurse Advice Line is available to Members and Providers 24/7 at (833) 657-1982 or TTY/TDD 711. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. PCPs are notified via fax of all Nurse Advice Line encounters.

Emergency Services

Emergency Services are inpatient and outpatient health care services that are Covered Services, including transportation needed to evaluate or stabilize an emergency medical condition, and which are furnished by a Provider qualified to furnish Emergency Services.

Emergency Medical Condition or Emergency means a medical condition manifesting itself in acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

A medical screening exam performed by licensed medical personnel in the Emergency Department and subsequent Emergency Services rendered to the Member do not require Prior Authorization from Molina.

Emergency Services are covered on a 24-hour basis without the need for Prior Authorization for all Members experiencing an emergency medical condition.

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

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

Members overutilizing the Emergency Department will be contacted by Molina Care Managers to provide assistance whenever possible and determine the reason for using Emergency Services.

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

Inpatient Management

Elective Inpatient Admissions

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

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care (including level of care), and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission, and clinical information sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting admission notification requirements, Medical

Necessity requirements, or the failure to include all the required clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay.

Inpatient at Time of Termination of Coverage
If a Member's coverage with Molina terminates during a hospital stay, all services received after termination of eligibility for a hospital with a per diem contract will **not** be Covered Services. For those Members whose coverage with Molina terminates while at a Diagnosis-Related Group (DRG) hospital, services are generally covered until date of discharge from that hospital.

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

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

Molina will authorize hospital care as an inpatient, when the clinical record supports the Medical Necessity for the need for continued hospital stay. It is the expectation that observation level of care has been tried in patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge, the Provider must provide Molina with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations
Molina's UM staff follow CMS guidelines to determine if the collected clinical information for requested services is "reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of malformed body member" by meeting all coverage, coding, and Medical Necessity requirements. Refer to the Medical Necessity subsection earlier in this section.

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

UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for our members. The clinical staff review Medical Necessity and appropriateness for home health, infusion therapy, Durable Medical Equipment (DME), Skilled Nursing Facility (SNF), and rehabilitative services.

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

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

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within two to 30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions, and the readmission will **not** be approved for coverage.

A readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:

- Premature or inadequate discharge from the same hospital.
- Issues with transition or coordination of care from the initial admission.
- For an acute medical complication plausibly related to care that occurred during the initial admission.

Readmissions that are excluded from consideration as preventable readmissions include:

- Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
- Neonatal and obstetrical readmissions.
- Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed.
- Behavioral Health readmissions.
- Transplant-related readmissions.

Post Service Review
Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment resulting from post-service review is if information is received indicating the Provider did not know nor reasonably could have known that the patient was a Molina Member or there was a Molina error; then a Medical Necessity Review will be performed. Decisions in this circumstance will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, regulation, guidance, and evidence-based criteria sets.

Specific federal or state requirements or Provider contracts that prohibit administrative denials supersede this policy.

Affirmative Statement About Incentives

All medical decisions are coordinated and rendered by qualified Molina physicians and licensed clinical staff who are unhindered by fiscal or administrative concerns. Molina and its delegated contractors **do not** use incentive arrangements to reward the restriction of medical care to Members.

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

Out-of-Network Providers and Services

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

Except for Emergency Services and out-of-area Urgent Care Services, Marketplace Members must receive Covered Services from Participating Providers; otherwise, the services are not covered. Marketplace Members will be 100% responsible for payment, and the payments will not apply to toward deductibles or annual out-of-pocket maximums.

Avoiding Conflict of Interest

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

Molina does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina never provides financial incentives to encourage

authorization decision makers to make determinations that result in under-utilization. Molina also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care and Services

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

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

Continuity of Care and Transition of Members

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

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

For additional information regarding continuity of care and transition of Members, please email Molina at CMEscalationIL@MolinaHealthcare.com or call **(855) 866-5462**.

Continuity and Coordination of Provider Communication

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

Reporting of Suspected Abuse and/or Neglect

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

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

- Physicians, dentists, interns, residents, or nurses.
- Public or private school employees or childcare givers.
- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers.

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

Child Abuse

For abuse, neglect, or exploitation of Members under the age of 18, call the Illinois Child Abuse Hotline (Department of Children and Family Services) 24/7 at **(800) 25ABUSE**—**(800) 252-2873**—or TTY **(800) 358-5117**. Doing so complies with the Abused and Neglected Child Reporting Act 325 ILCS 5/1 et seq. Call if you suspect that a child has been harmed or is at risk of being harmed by abuse or neglect. If you believe a child is in immediate danger, **call 911 first.**

Adult Abuse

For Members who are age 18 and older and living in the community, reports go to the Illinois Department on Aging via the Adult Protective Services Hotline number at **(866) 800-1409** or TTY/TDD **(800) 206-1327**. This complies with the Adult Protective Services Act 320 ILCS 20/1-1 et seq., the Abuse of Adults with Disabilities Intervention Act 20 ILCS 2435/1 et seq., and the Elder Abuse and Neglect Act 320 ILCS 20/1 et seq.

For Members residing in Supportive Living Facilities (SLF), reports go to the Department of Health care and Family Services' SLF Complaint Hotline at **(800) 226-0768**. This complies with the 89 Ill. Adm. Code, Section 146.305 for Reporting of Suspected Abuse, Neglect, and Financial Exploitation in Specialized Health Care Delivery Systems through the Department of Health care and Family Services Medical Programs.

For Members aged 18 to 59 receiving mental health or Developmental Disability services in DHS operated, licensed, certified, or funded programs, use the Illinois Department of Human Services Office of the Inspector General Hotline at **(800) 368-1463** (voice and TTY). Doing so complies with the Department of Human Services Act 20 ILCS 1305/1-1 et seq.

For Members who are residing in Nursing Facilities, reports go to the Department of Public Health's Nursing Home Complaint Hotline at **(800) 252-4343**. This complies with

the Abused and Neglected Long Term Care Facility Residents Reporting Act 210 ILCS 30/1 et seq.

To report suspected abuse, neglect, or financial exploitation of an adult age 60 or older or a person with disabilities age 18 to 59, call the statewide, 24-hour Adult Protective Services Hotline at **(866) 800-1409** or TTY/TDD (888) 206-1327.

Molina's HCS teams will work with PCPs, Medical Groups/IPAs, and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities, or other clinical personnel. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

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

PCP Responsibilities in Care Management Referrals

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

Care Manager Responsibilities

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

- Assesses the Member to determine if the Member's needs warrant care management.
- Monitors and communicates the progress of the implemented ICP to the Member's ICT, as Member needs warrant.
- Serves as a coordinator and resource to the Member, his/her representative(s), and ICT participants throughout the implementation of the ICP, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.

- Monitors progress toward the Member's achievement of ICP goals to determine an appropriate time for the Member's graduation from the ICM Program.

Health Management

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

Level 1 Health Management

Molina offers programs to help our Members and their families manage a diagnosed health condition. The Molina My Health programs include telephonic outreach from our clinical staff and health educators that includes condition-specific triage assessment, care plan development, and access to tailored educational materials. Members are identified via Health Risk Assessments (HRA), and identification and stratification.

Members can enroll in any of the programs by calling the Molina Health Management Department at (866) 891-2320 from 9:30 a.m. to 5:30 p.m. (PST), Monday through Friday. Providers can also directly refer Members who may benefit from these program offerings by contacting Molina's Health Care Services department at **(855) 866-5462**. Members can request to be enrolled or disenrolled in these programs at any time. Our programs include:

- Asthma
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD) management
- Substance Use Disorder
- Depression
- Heart Failure
- Hypertension
- Tobacco Cessation
- Nutrition Consult
- Weight Management

For information about the other programs, call **(866) 472-9483** (TTY/TDD at 711).

Maternity Screening and High-Risk Obstetrics (OB)

Molina offers all pregnant Members prenatal health education with resource information as appropriate, and screening services to identify high-risk pregnancy conditions. Care Managers with specialized OB training provide additional care coordination and health education for Members with identified high-risk pregnancies to assure best outcomes for Members and their newborns during pregnancy, delivery, and through their sixth week post-delivery. Pregnant Member outreach, screening, education, and Care Management are initiated by Provider notification to Molina, Member self-referral, and internal Molina notification processes. Providers can notify Molina of pregnant/high-risk pregnant Members via faxed Pregnancy Notification Report Forms.

Pregnancy Notification Process

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at MolinaMarketplace.com) within one working day of the first prenatal visit and/or positive pregnancy test.

The information may be phoned, faxed, or emailed to Molina:

Phone: (855) 687-7861
Fax: (844) 479-5341
Email:Quality-HealthCampaigns@MolinaHealthcare.com

For more info about our programs, please call Provider Network Management at **(855) 866-5462** (TTY/TDD 711).

Member Newsletters

Member Newsletters are posted on the MolinaMarketplace.com website at least once per year. The articles are about topics requested by Members. The tips are intended to help Members stay healthy.

Member Health Education Materials

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

Program Eligibility Criteria and Referral Source

Health Management (HM) Programs are designed for Molina Members with a confirmed diagnosis. Identified Members will receive targeted outreach, such as educational newsletters, telephonic outreach, or other materials to access information on their condition. Members can contact Molina Member Services at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include:

- Pharmacy claims data for all classifications of medications.
- Encounter Data or paid claims with a relevant CMS-accepted diagnosis or procedure code.
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- Member assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members.
- External referrals from Providers, caregivers, or community-based organizations.
- Internal referrals from the Nurse Advice Line, Medication Management, or Utilization Management.

- Member self-referral due to general plan promotion of the program through the Member newsletter or other Member communications.

Provider Participation

Contracted Providers are notified, as appropriate, when the Member is enrolled in a Health Management Program. Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease.
- Clinical resources, such as patient assessment forms and diagnostic tools.
- Patient education resources.
- Provider Newsletters promoting the Health Management Programs, including outcomes of the programs and how to enroll patients.
- Clinical practice guidelines
- Preventive health guidelines

Additional information on Health Management Programs is available from Molina's Health Care Services department toll free at **(855) 866-5462**.

Members may qualify for Molina's ICM Program based on confirmed diagnosis or specified criteria. The comprehensive programs are available for all Members who meet the criteria for services.

Primary Care Providers (PCP)

Molina provides a panel of Primary Care Providers (PCP) to care for its Members. Providers in the specialties of family medicine, internal medicine, and obstetrics and gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina. Members are required to see a PCP who is part of the Molina Network. Members may select or change their PCP by calling Molina Member Services at **(855) 687-7861** or TTY 711.

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no Prior Authorization is required. Members are allowed to directly access women's health specialists for routine and preventive health without a referral for services.

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

Care Management (CM)

Molina provides a comprehensive ICM Program to all Members who meet the criteria for services. The ICM Program focuses on coordinating the care, services, and resources needed by Members throughout the continuum of care. Molina adheres to Case

Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina Care Managers may be licensed professionals and are educated, trained, and experienced in Molina's ICM Program. The ICM Program is based on a Member-advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services to increase continuity and efficiency, and to produce optimal outcomes. The ICM Program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP.

The Molina Care Manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Care Manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of the ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

Referral to Care Management

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

Members with the following conditions may qualify for Care Management and should be referred to the Molina ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery.
- Catastrophic or end-stage medical conditions (e.g., neoplasm, organ/tissue transplants, End Stage Renal Disease).
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF, etc.).
- Members receiving seven or more medications.
- Preterm infants.
- High-tech home care requiring more than two weeks of treatment.
- Member accessing Emergency Department services inappropriately.
- Children with special health care needs.

Referrals to the ICM Program may be made by emailing Molina at:

Phone: (855) 687-7861
Email: CMEscalationIL@MolinaHealthcare.com

9. BEHAVIORAL HEALTH

Overview

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

Utilization Management and Prior Authorization

Behavioral Health inpatient and residential services can be requested by submitting a Prior Authorization form or contacting Molina's Prior Authorization team at **(855) 866-5462**, Monday through Friday from 8 a.m. to 5 p.m. Central Time (excluding state and federal holidays). Providers requesting after-hours authorization for these services should utilize Provider Portal or fax submission options. Emergency psychiatric services do not require Prior Authorization.

All requests for Behavioral Health services should include the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted Medical Necessity criteria for Prior Authorization reviews. Please see the Prior Authorization subsection found in the Health Care Services section of this Provider Manual for additional information.

Access to Behavioral Health Providers and PCPs

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

Members may be referred to PCP and specialty care Providers to manage their health care needs. Behavioral Health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Behavioral Health Providers may identify other health concerns, including physical health concerns, that should be addressed by referring the Member to a PCP.

Care Coordination and Continuity of Care

Discharge Planning

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

Interdisciplinary Care Coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration among all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care between each other for the benefit of the Member. Collaboration of the treatment team will increase the communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Molina's Care Management program may assist in coordinating care and communication among all Providers of a Member's treatment team. Additional information on the Care Management program can be found in the Care Management subsection found in the Health Care Services section of this Provider Manual.

Care Management

Molina's Care Management (CM) team includes licensed nurses and clinicians with Behavioral Health experience to support Members with mental health and Substance Use Disorder (SUD) needs. Members with high-risk psychiatric, medical, or psychosocial needs may be referred by a Behavioral Health Provider to the CM program.

Referrals to the Care Management program may be made by:

Phone: (855) 687-7861
Email: CMEscalationIL@MolinaHealthcare.com

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

Responsibilities of Behavioral Health Providers

Molina promotes collaboration between Providers and integration of both physical and Behavioral Health services in effort to provide quality care coordination to Members. Behavioral Health Providers are expected to provide in-scope, evidence-based mental health and SUD services to Molina Members. Behavioral Health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow quality standards related to access. Molina provides oversight of Providers to ensure that Members are able to obtain needed health services within the acceptable appointment time frames. Please see the Quality section of this Provider Manual for specific access to appointment details.

Molina requires patients in inpatient hospital settings to be seen by an appropriate physician (MD/DO) or advanced practice nurse every day. Face-to-face visits are preferred; however, telehealth visits may be used under certain circumstances. Refer to the Telehealth and Telemedicine Services subsection found in the Benefits and Covered Services section of this Provider for additional information.

- For Behavioral Health/mental health care, the provider seeing the member daily **must** be a psychiatrist (MD/DO) or a certified mental health nurse practitioner.

- Any inpatient stay that does not have a face-to-face evaluation by an appropriate physician or advanced practice nurse will result in denial of the day the member did not receive this level of care.

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

Behavioral Health Crisis Lines

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

Phone: (833) 657-1982 (TTY 711)

Behavioral Health Tool Kit for Providers

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

10. QUALITY

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality department toll free at **(855) 866-5462** or fax **(855) 556-2074**.

The address for mail requests:

Molina Healthcare of Illinois, Inc.
Quality Department
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

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

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

Molina does **not** delegate quality improvement activities to Medical Groups/IPAs. However, Molina requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care. Molina Medical Groups/IPAs must:

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

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe personal health practices for our Members through our Safety Program, Pharmaceutical Management, and Care Management/Disease Management Programs

and education. Molina monitors nationally recognized quality index ratings for facilities, including adverse events and hospital-acquired conditions, as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA) and Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

Molina has established a systematic process to identify, investigate, review, and report any quality of care, adverse event/Never Event, critical incident (as applicable), and/or service issues affecting Member care. Molina will research, resolve, track, and trend issues. Confirmed adverse events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable, and/or is found to have caused serious injury or death to a patient. Some examples of Never Events include:

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

Molina is **not** required to pay for inpatient care related to Never Events.

Medical Records

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

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

Medical Record-Keeping Practices

This list describes the minimum items that are necessary in the maintenance of the Member's Medical records:

- Each patient has a separate record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available at each visit, and archived records are available within 24 hours.
- If hardcopy, pages are securely attached in the medical record, and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record-keeping is monitored for quality and HIPAA compliance.

- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving medical records and implementing improvement activities.
- Medical records are kept confidential, and there is a process for release of medical records including behavioral health care records.

Content

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

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

- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals, and operative report.
- Labor and delivery record for any child seen since birth.
- Family planning and counseling, obstetrical history, and profile.
- A signed document stating with whom protected health information may be shared.

Organization

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

Retrieval

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

Confidentiality

Molina Providers shall develop and implement confidentiality procedures to guard Member Protected Health Information (PHI) in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include, and is not limited to:

- Ensure that medical information is released only in accordance with applicable federal or state law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure Members timely access to the records and information that pertain to them.
- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Medical Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining PHI.

Additional information on medical records is available from the Molina Quality department at **(855) 866-5462**. For additional information regarding HIPAA, please see the Compliance section of this Provider Manual.

Access to Care

Molina maintains Access to Care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs (adult and pediatric) and participating specialists (to include OB/GYN, behavioral health Providers, and high-volume and high-impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 90% availability for Emergency Services and 90% or greater for all other services. The PCP or designee must be available 24/7 to Members.

Appointment Access

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

Medical Appointment Access

Medical Appointment Types	Standard
Routine preventive care	Within 30 calendar days
Routine preventive care for infant under 6 months of age	Within two (2) weeks
Routine, symptomatic, but not deemed serious	Within seven (7) calendar days
Urgent care	Within 24 hours
After-hours/emergency care	24/7 year-round
Specialty care (high-volume)	Within 20 to 30 calendar days
Specialty care (high-impact)	Within 20 to 30 calendar days
Urgent specialty care	Within 24 hours
Initial prenatal visit—first trimester	Within two (2) weeks
Initial prenatal visit—second trimester	Within one (1) week
Initial prenatal visit—third trimester	Within three (3) days

Behavioral Health Appointment Access

Behavioral Health Appointment Types	Standard
Life-threatening emergency	Immediately
Non-life-threatening emergency	Within six (6) hours
Urgent care	Within 48 hours
Initial routine care visit	Within 10 business days
Follow-up routine care visit	Within 20 calendar days

Additional information on appointment access standards is available from the Molina Quality department at **(855) 866-5462**.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 60 minutes from appointment time. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

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

Women's Health Access

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

Additional information on access to care is available from your local Molina Quality department at **(855) 866-5462**.

Monitoring Access for Compliance with Standards

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

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

- Provider access studies—Provider office assessment of appointment availability, after-hours access, Provider ratios, and geographic access.

- Member complaint data—Assessment of Member complaints related to access and availability of care.
- Member satisfaction survey—Evaluation of Members' self-reported satisfaction with appointment and after-hours access.

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

Quality of Provider Office Sites

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

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

Physical Accessibility

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

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

During the site visit, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration & Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.

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

Advance Directives (Patient Self-Determination Act)

Molina complies with the Advance Directives requirements of the states in which the organization provides services. Responsibilities include ensuring Members receive information regarding Advance Directives, and that contracted Providers and facilities uphold executed documents.

Advance Directives are a written choice for health care. Illinois has four types of Advance Directives:

- **Health Care Power of Attorney**—Allows an agent to be appointed to carry out health care decisions.
- **Living Will**—Allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.
- **Do-Not-Resuscitate Order (DNR)**—A medical order stating that cardiopulmonary resuscitation cannot be performed if the heart or breathing stops.

- **Mental Health Treatment Preference Declaration**—Allows the Member to state whether they want to receive electroconvulsive treatment or psychotropic medicine.

The Absence of Advance Directives

The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

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

New adult Members or their identified personal representative will receive educational information and instructions on how to access Advance Directives forms in their Member Handbook, Evidence of Coverage (EOC), and other Member communications, such as newsletters and the Molina website. If a Member is incapacitated at the time of enrollment, Molina will provide Advance Directives information to the Member's family or representative, and will follow up with information to the Member at the appropriate time. All current Members will receive annual notice explaining this information, in addition to newsletter information.

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

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

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

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

Molina will notify the Provider of an individual Member's Advance Directives identified through Care Management, Care Coordination, or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the medical record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are state specific to meet state regulations.

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

Services to Enrollees Under 21 Years of Age

Molina maintains systematic and robust monitoring mechanisms to ensure all preventive services necessary for Members under 21 years of age are timely according to required preventive health guidelines. All Members under 21 years of age should receive screening examinations, including appropriate childhood immunizations, at intervals specified by the by the Preventive Health Guidelines found on the Molina Provider website and referenced in the Benefits and Covered Services section of this Provider Manual.

Well Child/Adolescent Visits

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

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height, weight, and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to the Advisory Committee on Immunization Practices.
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool.
- Vision and hearing tests.
- Dental assessment and services.
- Health education, including anticipatory guidance, such as child development, healthy lifestyles, and accident and disease prevention.
- Periodic objective screening for social emotional development using a recognized, standardized tool.
- Perinatal depression for mothers of infants in the most appropriate clinical setting (e.g., at the pediatric, behavioral health, or OB/GYN visit).

Diagnostic services, treatment, or services Medically Necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

Molina shall have no obligation to pay for services that are not Covered Services.

Monitoring for Compliance With Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Performance below Molina's standards may result in a Corrective Action Plan (CAP) with a request the Provider submit a written corrective action plan to Molina within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any

response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

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

Health Management and Care Management

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

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

Clinical Practice Guidelines

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

Molina Clinical Practice Guidelines include the following:

- Acute stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/panic disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Bipolar disorder
- Children with Special Health Care Needs
- Chronic kidney disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Community reintegration and support
- Coronary artery disease (CAD)
- Dental services
- Depression
-
- Diabetes
- Heart failure in adults
- Hypertension

- Long-Term Care (LTC) residential coordination of services
- Mental health
- Obesity
- Opioid management
- Perinatal Care
- Pharmacy services.
- Pregnancy management
- Prenatal, obstetrical, postpartum, and reproductive health care
- Psychotropic medication management
- Schizophrenia
- Sickle cell disease
- Smoking cessation
- Substance Abuse Treatment
- Suicide Risk
- Trauma-informed primary care

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates, and Members by the Quality, Provider Network Management, Health Education, and Member Services departments. The guidelines are disseminated through Provider newsletters, electronic Provider Bulletins, and other media and are available on the Molina website. Individual Providers or Members may request copies from the local Molina Quality department at **(855) 866-5462**.

Preventive Health Guidelines

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

- Adult preventive services recommendations
- Recommendations for preventive pediatric care
- Recommended adult immunization schedule for ages 19 years or older, United States, 2021
- Recommended child and adolescent immunization schedule for ages 18 years or younger, United States, 2021
-

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

Cultural and Linguistic Services

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

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
-
- Qualified Health Plan (QHP) Enrollee Experience Survey
- Behavioral Health Satisfaction Assessment
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

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

Contracted Providers and facilities must allow Molina to use 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:

- Development of quality improvement activities.
- Public reporting to consumers.
- Preferred status designation in the Network.
- Reduced Member cost-sharing.

Molina's most recent results can be obtained from Molina Quality department staff at **(855) 866- 5462** or fax **(855) 556-2074** or by visiting our website at MolinaMarketplace.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)

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

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

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

Qualified Health Plan (QHP) Enrollee Experience Survey

The QHP Enrollee Experience survey is a consumer experience survey that assesses Enrollee (Member) experience with QHPs offered through Marketplaces. This survey is fielded nationally by Department of Health & Human Services (HHS)-approved survey vendors using a standardized protocol to facilitate QHP comparison both within and across Marketplaces.

The QHP Enrollee Experience survey was designed to collect accurate and reliable information from consumers about their experience with the health care they received through QHPs in the Health Insurance Marketplace. The survey includes a set of core questions that address key areas of care and service, with some questions grouped to form composites.

QHP Enrollee survey topics include:

- Access to care
- Access to information
- Care coordination
- Cost
- Cultural competence
- Doctor's communication
- Plan administration
- Prevention

Behavioral Health Satisfaction Assessment

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

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® Qualified Health Plan Enrollee Experience surveys both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider Network. The survey results have helped establish improvement activities relating to Molina's specialty Network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

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

In addition to the methods described above, Molina also compiles complaint and appeals data, as well as data on requests for out-of-network services to determine opportunities for service improvements.

Quality Rating System

Based on Section 1311(c)(3) of the Affordable Care Act, CMS developed the Quality Rating System (QRS) to:

- Provide comparable and useful information to consumers about the quality of health care services provided by QHPs.
- Facilitate oversight of QHP-issuer compliance with Marketplace quality standards.
- Provide actionable information for improving quality and performance.

Quality ratings are calculated for each eligible QHP product using clinical quality and Enrollee experience survey data. Based on results, CMS will calculate and produce quality performance ratings for each health plan on a one- to five-star rating scale.

Measures are organized into a hierarchical structure designed to make the QRS scores and ratings more understandable. They include but are not limited to:

- Clinical effectiveness
- Patient safety
- Prevention
- Access and coordination
- Doctor and care
- Efficiency and affordability
- Plan service

What Can Providers Do?

- Ensure that patients are up to date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology.
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to the patient's age and/or condition has been missed.
- Check that staff is properly coding all services provided.
- Be sure that patients understand what **they** need to do.

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Provider Portal. In it are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To

obtain a current list of HEDIS® and CAHPS®/QHP Enrollee Experience Survey Star Ratings measures, contact the Molina Quality department.

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

11. RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

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

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

Why Is Risk Adjustment Important?

Molina relies on our Provider Network to take care of our Members based on their health care needs. Risk adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, risk adjustment allows us to:

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

Your Role as a Provider

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

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

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

Interoperability

Provider agrees to deliver relevant clinical documents—Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format—at encounter close for Molina members by using one of the automated methods available and supported by the Provider's Electronic Medical Records (EMR), including but not limited to Direct Protocol, Secure File Transfer Protocol (sFTP), query, or web service interfaces such as Simple Object Access Protocol (SOAP External Data Representation) or Representational State Transfer (REST Fast Healthcare Interoperability Resource). CDA or CCD document should include signed clinical notes or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

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

Provider will participate in Molina's program to communicate clinical information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act (HIPAA)-compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If Provider does not have Direct Address, Provider will work with its EMR vendor to set up a Direct Account, which also supports the Centers for Medicare & Medicare Services (CMS) requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).
- If Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.

Risk Adjustment Data Validation (RADV) Audits

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

Contact Information

For questions about Molina's Risk Adjustment programs, please contact your Provider Network Manager.

12. COMPLIANCE

Fraud, Waste, and Abuse

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan that addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste, and abuse prevention and detection, along with the education of appropriate employees, vendors, Providers, and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports compliance in its efforts to detect, deter, and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission Statement

Molina regards health care fraud, waste, and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina has therefore implemented a plan to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

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

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

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

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

Deficit Reduction Act

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

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

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

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

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against due to their role in disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole, including:

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

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

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

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

Sarbanes-Oxley Act of 2002—Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud—An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or

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

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

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

Examples of Fraud, Waste, and Abuse by a Provider

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

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

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

Examples of Fraud, Waste, and Abuse by a Member

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

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud state and federal health care programs.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from and the Member sells the medication to someone else.

Review of Provider Claims and Claims System

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

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

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

Prepayment Fraud, Waste, and Abuse Detection Activities

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

Molina has a prepayment claims auditing process that identifies frequent correct coding billing errors, ensuring that claims are coded appropriately according to state and federal coding guidelines. Code edit relationships and edits are based on guidelines from Centers for Medicare & Medicaid Services (CMS), federal CMS guidelines, AMA, and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule (NPFS) relative file, the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), and state-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

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

Post-Payment Recovery Activities

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

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

The Provider will provide Molina, and governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, at Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste, and abuse. Documents and records must be readily accessible at the location where the Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts, patient charts, billing records, and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina, and without charge to Molina. In the event Molina identifies fraud, waste, or abuse, Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to Provider's records, all of the claims for which Provider received payment from Molina is immediately due and owing. If Provider fails to provide all requested documentation for any claim, the entire amount of the paid claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without

charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

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

Claim Auditing

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

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

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

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

If Molina's Special Investigations Unit suspects fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to facilities, Molina reserves the right to recover the full amount paid or due to Provider.

Provider Education

When Molina identifies through an audit or other means a situation with a Provider that is either inappropriate or deficient (e.g. coding, billing), Molina may determine that a Provider education visit is appropriate.

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a Corrective Action Plan (CAP) to

Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. AlertLine reporting is available 24/7 year-round. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions before submitting your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached at **(866) 606-3889** or you may use the service's website: MolinaHealthcare.alertline.com.

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

Molina Healthcare of Illinois, Inc.
Attn: Compliance
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523
Phone: (888) 858-2156
Fax: (630) 571-1220

Include the following information when reporting:

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

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

Illinois Attorney General
Online: illinois.gov/hfs/oig/Pages/ReportFraud.aspx

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

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

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

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

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

Applicable Laws

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

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

2. **State Medical Privacy laws and Regulations.**
   Providers should be aware that HIPAA provides a floor of standards for patient privacy, but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosure of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for its own Treatment, Payment, and Operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or

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

health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2].

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

    - Quality improvement.
    - Disease management.
    - Care management and care coordination.
    - Training programs.
    - Accreditation, licensing, and credentialing.

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

Confidentiality of Substance Use Disorder Patient Records

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

Inadvertent Disclosures of PHI

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

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

Written Authorizations

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

Patient Rights

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

1. **Notice of Privacy Practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.
2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.
3. **Requests for Confidential Communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.
4. **Requests for Patient Access to PHI**
   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.
5. **Request to Amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.
6. **Request Accounting of PHI Disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cybersecurity measures. Providers should recognize that identity theft—both financial and medical—is a rapidly growing problem, and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

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

HIPAA Transactions and Code Sets

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

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

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

Code Sets

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

National Provider Identifier (NPI)

Providers must comply with the National Provider Identifier (NPI) rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina within 30 days of the change. Providers must use their NPI to identify itself on all electronic transactions required under HIPAA and on all claims and encounters submitted to Molina.

Additional Requirements for Delegated Providers

Providers that are delegated for claims and Utilization Management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's privacy and security rules.

Reimbursement for Copies of PHI

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

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

Business Continuity Plan (BCP)

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

The Provider BCP will include:

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

The Provider will notify Molina of a disruption to the services or activation of BCPs within two hours, and will provide Molina with regular updates on the situation and actions taken to resolve the issue until normal services resume.

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

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

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

Once normal service has resumed after a disruption to services, the Provider will promptly complete a root-cause analysis report and provide it to Molina.

Definitions

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

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

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

Cybersecurity Requirements

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

1. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by law or any enforcement agency.
2. The following terms are defined:
    - I. "Consumer"—An individual who is a state resident, whose Nonpublic Information is in Molina's possession, custody, or control and which Provider maintains, processes, stores, or otherwise has access to such Nonpublic Information.
    - II. "Cybersecurity Event"—Any act or attempt (successful or, to the extent known by Provider, unsuccessful) to gain unauthorized access to, disrupt, or misuse an Information System or Nonpublic Information stored on such Information System. The ongoing existence and occurrence of attempted but unsuccessful security incidents shall not constitute a Cybersecurity Event under this definition.
    - III. "Unsuccessful Security Incidents"—Activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful login attempts, denials of service, and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Molina Nonpublic Information, or sustained interruption of service obligations to Molina.
    - IV. "Information System" or "Information Systems"—A discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic Nonpublic Information, as well as any specialized system, such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.
    - V. "Nonpublic Information"—Information that is not publicly available information and is one of the following:
        - (a) Business-related information of Molina, the tampering with which or unauthorized disclosure, access, or use of which would cause a

material adverse impact to the business, operations, or security of Molina.

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

(i) Social Security number.

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

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

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

(v) Biometric records.

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

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

(ii) The provision of health care to a Consumer.

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

VI. "State"—The State of Illinois.

3. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information as defined herein, that are accessible to or held by the Provider. Implementation of the foregoing measures shall incorporate guidance issued by the state's Department of Insurance, as appropriate.

4. Provider agrees to comply with all applicable laws governing Cybersecurity Events. Molina will decide on notification to affected Consumers or government entities. Upon Molina's prior written request, Provider agrees to assume responsibility for informing all such Consumers in accordance with applicable law.

5. In the event of a Cybersecurity Event, Provider shall notify Molina's Chief Information Security Officer of such Cybersecurity Event by telephone and email (as provided below) as promptly as possible, but in no event later than 72 hours from a determination that a Cybersecurity Event has occurred. A follow-up notification shall be provided by mail, at the address indicated below.

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

Molina Chief Information Security Officer
Phone: (844) 821-1942
Email: CyberIncidentReporting@molinahealthcare.com
Molina Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

6. Upon Provider's notification to Molina of the determination of a Cybersecurity Event, Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation or, upon written request by Molina, Provider shall complete an investigation pursuant to these requirements:
   (a) Determine whether a Cybersecurity Event occurred.
   (b) Assess the nature and scope of the Cybersecurity Event.
   (c) Identify any Nonpublic Information that may have been involved in the Cybersecurity Event.
   (d) Perform or oversee reasonable measures to restore the security of the Information Systems compromised by the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of the Nonpublic Information.
7. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five years from the date of the Cybersecurity Event, or such longer period as required by applicable laws, and produce those records upon request of Molina.
8. Provider must provide to Molina the documentation required and requested by Molina in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina in the initial and subsequent notices must include as much of following information that known to Provider at the time of the notification:
   (a) Date(s) of the Cybersecurity Event.
   (b) A description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Provider, if any.
   (c) How the Cybersecurity Event was discovered.
   (d) Whether any lost, stolen, or breached information has been recovered and, if so, how this was done.
   (e) The identity of the source of the Cybersecurity Event.
   (f) Whether Provider has filed a police report or has notified any regulatory, governmental, or law enforcement agencies and, if so, when such notification was provided.

(g) A description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the Consumer.

(h) The period during which the Information System was compromised by the Cybersecurity Event.

(i) The number of total Consumers in the state affected by the Cybersecurity Event.

(j) The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed.

(k) A description of efforts being undertaken to remediate the situation that permitted the Cybersecurity Event to occur.

(l) A copy of Provider's privacy policy and, if requested by Molina, the steps that Provider will take to notify Consumers affected by the Cybersecurity Event.

(m) The name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

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

13. CLAIMS AND COMPENSATION

Molina Payer ID	**20934**
Provider Portal	**molina.sapphirethreesixtyfive.com**
Clean Claim Timely Filing	**180 Days**

Electronic Claims Submission

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

- Reduces operations costs associated with paper claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces claim delays, since errors can be corrected and resubmitted electronically.
- Eliminates mailing time so claims reach Molina faster.

Molina offers the following electronic claims submission options:

- Submit claims directly to Molina via the Provider Portal.
- Submit claims to Molina via your regular EDI clearinghouse using **Payer ID 20934**.

EDI Claims Submission Issues

Providers who are experiencing EDI submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may email Molina at EDI.claims@MolinaHealthcare.com for additional support.

Provider Portal

The Provider Portal is a no-cost online platform that offers several claims-processing features:

- Submit Professional (CMS-1500) and Institutional (UB-04) claims with attached files.
- Correct/void claims.
- Add attachments to previously submitted claims.
- Check claims status.
- Explanation of Payment (EOP).
- Create and manage claim templates.
- Create and submit a claim appeal with attached files.

Clearinghouse

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

Molina accepts EDI transactions through our gateway clearinghouse for claims via 837P for Professional and 837I for Institutional. It is important to track your electronic

transmissions using your acknowledgement reports. The reports assure that 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 claim from your clearinghouse.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

HIPAA 5010 Transaction Compliance Standards Implementation

Molina accepts and issues all Electronic Data Interchange (EDI) HIPAA transactions in Version 5010 format, regulated by CMS. The 4010A1 transaction standards are no longer permitted.

Timely Claim Filing

Provider shall promptly submit to Molina claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within 180 calendar days after the discharge for inpatient services or the date of service for outpatient services.

If Molina is not the primary payer under Coordination of Benefits or third-party liability, Provider must submit claims to Molina within 90 calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any claims that are not submitted to Molina within these timelines shall not be eligible for payment, and Provider hereby waives any right to payment.

Claim Submission

Participating Providers are required to submit claims to Molina with appropriate documentation. Providers must follow the appropriate state and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or the Provider Portal whenever possible and use current HIPAA-compliant ANSI X 12N format (e.g., 837I for Institutional claims, 837P for professional claims, and 837D for Dental claims). For Members assigned to a delegated Medical Group/IPA that processes its own claims, please verify the claim submission instructions on the Member's Molina ID card.

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

National Provider Identifier (NPI)

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

Required Elements

The following information **must** be included on every claim:

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

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

Paper Claim Submissions

Participating Providers should submit claims electronically. If electronic claim submission is not possible, you may submit paper claims to:

Molina Healthcare of Illinois, Inc.
P.O. Box 540
Long Beach, CA 90806

Please keep the following in mind when submitting paper claims:

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

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and UB-04 forms. Corrected claims may be submitted electronically via EDI in the Provider Portal (preferred method). All corrected claims must:

- Be free of handwritten or stamped verbiage (paper claims).

- Be submitted on a standard red UB-04 or CMS-1500 Claim form (paper claims).
- Include the original claim number in field 64 of the UB-04 or field 22 of the CMS-1500 (paper claim), or the applicable 837 transaction loop for submitting corrected claims electronically.
- Include the appropriate frequency code/resubmission code in field 4 of the UB-04 and 22 of the CMS-1500.

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

Corrected claims must be sent within 180 calendar days of adjudicated date of the Claim.

Important: Claims submitted without the correct coding will be returned to the Provider for resubmission.

EDI (Clearinghouse) Submission

837P:

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
  - "1"—ORIGINAL (initial claim).
  - "7"—REPLACEMENT (replacement of prior claim).
  - "8"—VOID (void/cancel of prior claim).
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I:

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

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

For Members enrolled in a Molina Marketplace plan, Molina and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these Members. Molina Marketplace will pay claims for Covered Services. However, if COB/TPL is determined post-payment, Molina Marketplace will attempt to recover any overpayments.

Hospital-Acquired Conditions and Present on Admission Program

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

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

1. Foreign object retained after surgery.
2. Air embolism.
3. Blood incompatibility.
4. Stage III and IV pressure ulcers.
5. Falls and trauma:
    a) Fractures.
    b) Dislocations.
    c) Intracranial injuries.
    d) Crushing injuries.
    e) Burn.
    f) Other injuries.
6. Manifestations of poor glycemic control:
    a) Hypoglycemic coma.
    b) Diabetic ketoacidosis.
    c) Nonketotic hyperosmolar coma.
    d) Secondary diabetes with ketoacidosis.
    e) Secondary diabetes with hyperosmolarity.
7. Catheter-associated Urinary Tract Infection (UTI).
8. Vascular catheter-associated infection.
9. Surgical-site infection following coronary artery bypass graft—mediastinitis.
10. Surgical-site infection following certain orthopedic procedures:
    a) Spine.
    b) Neck.
    c) Shoulder.
    d) Elbow.
11. Surgical-site infection following bariatric surgery procedures for obesity:
    a) Laparoscopic gastric restrictive surgery.
    b) Laparoscopic gastric bypass.
    c) Gastroenterostomy.
12. Surgical-site infection following placement of Cardiac Implantable Electronic Device (CIED).
13. Iatrogenic pneumothorax with venous catheterization.
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following certain orthopedic procedures:
    a) Total knee replacement.
    b) Hip replacement.

What this Means to Providers

- Acute Inpatient Prospective Payment System (IPPS) Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

For more information regarding the Medicare HAC/POA program, including billing requirements, visit the CMS website cms.hhs.gov/HospitalAcqCond/.

Molina Coding Policies and Payment Policies

Frequently requested information on Molina's Coding Policies and Payment Policies is available on the MolinaMarketplace.com website under the Policies tab. Questions can be directed to your Provider Network Manager.

Reimbursement Guidance and Payment Guidelines

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

Molina utilizes a claims adjudication system that encompasses edits and audits that follow state and federal requirements, and administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including Procedure-to-Procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). If a professional organization has a more stringent/restrictive standard than a federal MUE, the professional organization standard may be used.
  - Medicare National Coverage Determinations (NCD).
  - Medicare Local Coverage Determinations (LCD).
  - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than federal guidelines.
- Molina policies based on the appropriateness of health care and Medical Necessity.
- Payment policies published by Molina.

Telehealth Claims and Billing

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

All telehealth claims for Molina Members must be submitted to Molina with correct codes for the plan type. Use the telehealth Place of Service (POS) code 02, which certifies that the service meets the telehealth requirements. By coding and billing a POS 02 with a covered telehealth procedure code, the Provider is certifying the Member was present at an eligible originating site when the telehealth services were performed. Modifier GQ/GT/95 is required when applicable.

- GQ represents services provided not in real time, such as remote patient monitoring or "store and forward" of information like photographs.
- GT represents services provided in real time (such as through video consultations).
- Modifier 95 is used for commercial insurance in place of GT for a set of specific Evaluation and Management (E&M) codes, as Medicare limits originating site to rural areas. POS 02 (telehealth) indicates that telehealth was the place of service. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

National Correct Coding Initiative (NCCI)

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

NCCI Procedure-to-Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an Evaluation and Management (E&M) code will bundle into the procedure when performed by the same physician, and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures.

NCCI editing also includes Medically Unlikely Edits (MUE) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

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

CPT and HCPCS Codes

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

Modifiers

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

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

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

ICD-10-CM/PCS Codes

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

Place of Service (POS) Codes

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

Type of Bill

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

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. Certain revenue codes require CPT/HCPCS codes to be billed. For a

complete list of codes, reference the NUBC's Official UB-04 Data Specifications Manual.

Diagnosis Related Group (DRG)

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

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

National Drug Code (NDC)

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

Providers **must** submit claims with both HCPCS and NDC codes with the **exact** NDC that appears on the medication packaging in the "5-4-2 digit" format (i.e., xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding Sources

Definitions

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

- Category I Code—Procedures/services.
- Category II Code—Performance Measurement.
- Category III Code—Emerging Technology.

HCPCS—HealthCare Common Procedural Coding System: a CMS-maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply, and Durable Medical Equipment (DME) codes furnished by physicians and other health care professionals.

ICD-10-CM—International Classification of Diseases, 10th Revision, Clinical Modification: ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS—International Classification of Diseases, 10th Revision, Procedure Coding System: used to report procedures for inpatient hospital services.

Claim Auditing

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

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

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

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

If Molina's Special Investigations Unit suspects fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Timely Claim Processing

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

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

Electronic Claim Payment

Participating Providers are **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, provide 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 MolinaMarketplace.com or by contacting our Provider Network Management department.

Overpayments and Incorrect Payments Refund Requests

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

1. Submit a refund to satisfy overpayment.
2. Submit request to offset from future claim payments.
3. Dispute overpayment findings.

Instructions will be provided on the Overpayment Notice, and overpayments will be adjusted and reflected in the remittance advice. The letter time frames are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling, including the policy number, effective date, term date, and subscriber information. For Members with Commercial COB, Molina will provide notice within 270 days from the claim's paid date if the primary insurer is a commercial plan.

For Members with Medicare COB, Molina will provide notice within 540 days from the claim's paid date if the primary insurer is a Medicare plan. A Provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the claim, and pay or deny the claim in accordance with claim processing guidelines.

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

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

Claim Disputes/Reconsiderations

Providers disputing a previously adjudicated claim must request such action within 60 calendar days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.), all claim disputes **must** be submitted on the Molina Claims Dispute Request Form found on

Provider website and the Provider Portal. The form **must** be filled out completely in order to be processed.

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

- Any documentation to support the adjustment, as well as a copy of the Authorization form (if applicable), must accompany the reconsideration request.
- The claim number clearly marked on all supporting documents.

Requests for claims disputes/reconsiderations should be sent via the following methods:

- **Provider Portal**: Providers may submit their appeals and disputes along with supporting documentation through the online Provider Portal. The Portal can be accessed on the Molina Provider home page: Provider Portal.
- **Fax**: A Claims Dispute Request Form is required when submitting via fax. The completed Claims Dispute Request Forms, along with supporting documentation, may be faxed to Molina at **(855) 502-4962**. The Claims Dispute Request Form is on the Forms & Documents page of Molina's Marketplace Provider website.

Note: Requests for adjustments of claims paid by a delegated Medical Group/IPA must be submitted to the group responsible for payment of the original claim.

The Provider will be notified of Molina's decision in writing within 60 days of receipt of the claims Dispute/Adjustment request.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require Prior Authorization.

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

Fraud and Abuse

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

Encounter Data

Each Provider, capitated Provider, or organization delegated for claims processing is required to submit Encounter Data to Molina for all adjudicated claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program, and HEDIS® reporting.

Encounter data must be submitted at least once per month, and within 365 days from the Date of Service in order to meet state and CMS encounter submission threshold

and quality measures. Encounter Data must be submitted via HIPAA-compliant transactions, including the ANSI X12N 837I – Institutional; 837P – Professional; and 837D – Dental. Data must be submitted with claims-level detail for all non-institutional services provided.

Molina has a comprehensive automated and integrated Encounter Data system capable of supporting all 837 file formats and proprietary formats if needed.

Providers must correct and resubmit any encounters that are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within 15 days of the rejection/denial.

Molina has created 837P, 837I, and 837D Companion Guides with the specific submission requirements; these are available to Providers.

When encounters are filed electronically, Providers should receive two types of responses:

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

Molina's Marketplace Payment Rate

Molina's Marketplace payment rate does not include any add-on payments, adjustments, or deductions that are only allowed for a Medicare Member, including but not limited to:

- Uncompensated Disproportionate Share Hospital (DSH) payments.
- Operating and capital DSH payments.
- Operating and capital Indirect Medical Education (IME) payments.
- Direct graduate medical education expense payments.
- Deductions for sequestration.

14. PROVIDER DISPUTES AND COMPLAINTS, AND ENROLLEE APPEAL AND GRIEVANCE PROCESSES

Provider Claim Dispute Process

A request to review the processing, payment, or non-payment of a claim by Molina shall be classified as a Provider Claim Dispute and can be submitted through one of the following options:

- **Provider Portal**: Providers are strongly encouraged to use the Provider Portal to submit Provider Claim Disputes.
- **Fax**: Provider Claim Disputes can be faxed to Molina at **(855) 502-4962**. They must also contain a completed Claims Dispute Form.

  Note: CDs containing medical records may be sent to:
  Molina Healthcare of Illinois, Inc.
  Attention Provider Disputes
  1520 Kensington Rd., Suite 212
  Oak Brook, IL 60523

Provider **must** include a completed Claims Dispute Form. One claim per dispute form.

A contracted Provider may request reconsideration of a claim on his/her behalf by submitting a completed Claims Dispute Form with supporting documentation as appropriate. The Claims Dispute Form must be completed to document the review request. It can be found the Forms & Documents page of Molina's Provider website.

All Provider reconsiderations for payment or non-payment must be submitted to Molina within 90 calendar days from the date of original remittance advice. All requests received after this time frame will be denied for untimely filing. An upheld resolution letter will be sent to the Provider.

To dispute timely filing, Providers must submit documentation to support their timely filing. Acceptable documentation of timely filing is a signed receipt by Molina staff for registered postal or commercial delivery system.

Molina will have 60 business days to process a claims-related dispute or reconsideration request. All requests submitted without appropriate documentation will be denied for lack of information. The Provider will be responsible for providing the appropriate requested documentation within 90 calendar days from the original remittance date. Molina or a regulatory agency may request medical records during the reconsideration process; the Provider shall **not** charge the Enrollee or Molina for requested records submitted for the reconsideration.

Provider Complaints

Providers have the right to file a complaint if they are dissatisfied with any aspect of operation or service rendered by Molina that **does not** pertain to a benefit or claim determination. Complaints may be submitted no later than 30 calendar days from the

date the Provider becomes aware of the issue generating the complaint. Provider complaints can be sent to Molina at:

Fax: (855) 502-4962

Molina Healthcare of Illinois, Inc.
Attention Provider Complaints Dept.
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Enrollee Appeals Processes

Molina Enrollees or the personal representatives of Enrollees have the right to file a grievance and submit an appeal through a formal process. All appeals must first be submitted to Molina within 180 days of the Adverse Benefit Determination. Appeals not resolved wholly in the Enrollee's favor can be appealed to the Illinois Department of Healthcare and Family Services (HFS). However, the filing of an appeal does not preclude the Enrollee from filing a complaint with HFS.

This section addresses the identification, review, and resolution of Enrollee's appeal. Molina's Enrollee Appeals Process is as follows. Appeals may be submitted by Enrollees or an authorized representative, such as a family member or the Provider, on behalf of the Enrollee in response to an Adverse Benefit Determination. If the appeal is submitted by someone other than the Enrollee, a signed Molina Healthcare of Illinois Authorized Representative Designation form must be included with submission. If Molina's decision is to deny a service in whole or part, Enrollees and Providers are notified of the following at the time of denial:

- Their right to appeal the decision.
- The process by which the appeal process is initiated.
- The Molina Member Services phone number, where more information regarding the appeals process can be obtained.
- The availability of the Illinois State Department of Insurance.

Enrollee Types of Appeals

An Enrollee may request an expedited or standard appeal. Appeals may be filed orally or in writing. Appeals are filed to request that Molina change an adverse determination for care or services submitted by the Enrollee or authorized representative. Appeals may be requested within 180 days of the Adverse Benefit Determination notice.

An expedited appeal request is submitted to the plan for review of an Adverse Benefit Determination if the standard appeal time frame indicates such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Enrollee Authorized Representative

An Enrollee may appoint an authorized representative to act on his/her behalf. The representative may be a guardian, caretaker, relative, health care Provider, or an attorney. Any standard appeals requested on behalf of the Enrollee must have written authorization from the Enrollee. If an authorized representative is filing an appeal on behalf of an Enrollee, an Authorized Representative Designation Form must be completed, signed by the Enrollee, and submitted with the appeal request. Molina can provide the form as needed.

Molina will ensure that no punitive action is taken against a Provider who acts as an authorized representative on behalf of the Enrollee or supports an appeal filed by an Enrollee.

Enrollee Standard Appeals Process and Timeline

Standard appeals may be received orally or in writing within 180 calendar days following the date of the notice of action. An oral appeal request may be filed by calling Molina's Member Services department. However, all oral appeals must be followed up with a written request signed by the Enrollee. Standard appeal requests submitted in writing should be sent to:

Fax: (855) 502-5128
Molina Healthcare of Illinois, Inc.
Attention Enrollee Appeals and Grievance
1520 Kensington Road, Suite 212
Oak Brook, IL 60523

All appeal requests must include the Enrollee's name, address, Member ID number, reasons for appealing, and documentation or evidence such as medical records, physician letters, or other important information that explains the reason the service or item is needed. An Authorized Representative Form should be attached to the request when appropriate on behalf of an Enrollee. An appeal request submitted after the 180-day time frame must provide good cause (such as the Enrollee being seriously ill preventing the ability to file the appeal) in order for Molina to consider the late request.

Upon receipt of an appeal, Molina will notify the party filing the appeal of all information that is required to evaluate the appeal. A written acknowledgement will be sent to the Enrollee within three business days.

No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal.

Written notifications of the appeal decision will contain reasons for the determination, including the medical or clinical criteria used to make the determination.

Time Frames for Responding to an Appeal

Request Type	Time Frame for Decision
Pre-Service Appeals	Molina will notify the Member in writing of Molina's appeal decision as soon as practical, taking into account the medical circumstances, but not later than 15 business days after Molina's receipt of the Member's appeal.
Post-Service Appeals	Molina will notify the Member in writing of Molina's appeal decision as soon as practical, which generally will not be later than 15 business days after Molina's receipt of all information necessary to complete the appeal. However, in extraordinary circumstances, Molina will have up to 60 calendar days from the date that the Member submits an appeal to provide the Member with notification of Molina's appeal decision.
Expedited Appeals (Urgent Care Service Decisions)	Molina will give the Member oral notice of Molina's appeal decision as soon as possible, considering the medical circumstances, but not later than either of the following time frames: • 24 hours from the time that Molina receives all information necessary to complete the appeal. • 72 hours from Molina's receipt of the Member's appeal.

If the Enrollee is dissatisfied with the outcome of an appeal, the Enrollee or authorized representative may request an external independent review. A request may be made within four months of receiving the adverse appeal decision. Review will be completed at no cost to the enrollee. To request a review, contact:

Illinois Department of Insurance Office of Consumer
Health Insurance External Review Unit
320 W. Washington Street
Springfield, IL 62767

Phone: (877) 850-4740
Fax: (217) 557-8495
Email: DOI.externalreview@illinois.gov
Online: mc.insurance.illinois.gov/messagecenter.nsf

Enrollee Expedited Internal Appeals Process and Timeline

Expedited appeals may be received orally or in writing within 180 days from the date of the notice of action. Any requests submitted in writing should be sent to the address or fax number above under the Standard Appeal Process section. Expedited appeal requests on behalf of the Enrollee do not require signed written consent of the Enrollee. A request to expedite an appeal will be considered in situations where applying the standard appeal time frame could seriously jeopardize the Enrollee's life, health, or ability to regain maximum function. An expedited review is not possible when services have already been provided to the Enrollee.

Upon receipt of appeal, Molina will notify the party filing the appeal as soon as possible, and within no more than 24 hours after receipt, of all information that is required to evaluate the appeal.

Molina will render a decision within 24 hours after receiving the required information. If additional information required to make the final appeal determination is not received within 72 hours, a determination will be made with the current information available.

If it is determined the expedited appeal request does not meet expedited criteria, the request will be processed under the standard appeal time frame of 15 business days from the date the request was received.

Molina will orally notify the party filing the appeal, the Enrollee (or designated representative), the Enrollee's PCP, the requesting provider, and any health care provider who recommended the service involved in the appeal, of its decision. Oral notification will be followed up by a written notice of determination within two calendar days following the oral notification.

Please note that expedited review is not available for retrospective adverse or final adverse determinations, per 215 ILCS 180/40(i).

Enrollee External Independent Review

Enrollees may skip an internal appeal and standard review and request an expedited (quick) appeal in the following instances:

An expedited (quick) appeal is available to Enrollees if their Provider thinks their life or health is in immediate danger. An Expedited External Independent Appeal can be requested orally or in writing. Molina will give the Enrollee oral notice of the appeal decision as soon as possible, considering the medical circumstances, but no later than either of the following time frames: two business days after receipt of all information necessary to complete the appeal; or 24 hours from receipt of the appeal, if Molina has all the information needed to make a decision. A 14-day extension can be made if requested by the Enrollee. Molina can apply a 14-day extension if it is in the best interest of the Enrollee. Enrollee must be notified of the extension.

Once a decision is reached the enrollee will be notified.

An External Appeal can be requested when Molina has denied an Enrollee's request for the provision of or payment for a health care service or course of treatment. Enrollees have the right to have Molina's decision reviewed by an independent review organization not associated with Molina by submitting a written request for an external review to:

Department of Insurance
Office of Consumer Health Information
320 West Washington Street, 4th Floor
Springfield, IL 62767

Enrollees can request external review prior to exhausting the Molina internal process, except in regard to appeals of services already provided.

External Appeals can be requested prior to the completion of the internal appeal if:

- The Enrollee has a medical condition wherein the time frame for completion of an internal appeal would seriously jeopardize the Enrollee's life or health, or would jeopardize his/her ability to regain maximum function.
- If review of the internal appeal has been delayed by Molina by 30 days for concurrent or prospective and 60 days for retrospective.
- If expedited internal appeal has been delayed by Molina for more than 72 hours.
- For experimental/investigational Enrollees may file for an expedited external review if delay of the recommended health service would be significantly less effective if delayed.
- If a final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the Enrollee received emergency services, but have not been discharged from a facility.
- If Molina fails to adhere to the requirements of the appeal process, as outlined above, you may have the right to request external review or other remedies under state law.

Requesting an External Review

External reviews will be conducted by an Independent Review Organization (IRO). Molina will not choose or influence the IRO reviewers. Enrollees must request a standard external review within four months of the exhaustion of Molina's internal appeal process. A request for an expedited (quick) external review has no filing deadline. All requests must be in writing. Molina will initiate the external review by notifying the Department of Insurance, Office of Consumer Health Information of the Enrollee's request, which will assign the IRP to conduct the external review. For standard external review requests, Molina will notify the Enrollee in writing of the assignment to an IRO. Molina will pay the costs of the external review.

For questions about External Appeal rights or assistance with the external review process, Enrollees and their representatives may contact:

Illinois Department of Insurance Office of Consumer
Health Insurance External Review Unit
320 W. Washington Street
Springfield, IL 62767

Phone: (877) 850-4740
Fax: (217) 557-8495
Email: DOI.externalreview@illinois.gov
Online: mc.insurance.illinois.gov/messagecenter.nsf

Enrollee Grievance Process

Molina has an organized grievance process to ensure thorough, appropriate, and timely resolution to an Enrollee's grievances. A grievance is an expression of dissatisfaction that may include, but is not limited to:

- Requests for disenrollment.
- Difficulty finding a provider.
- Unhappiness with the Prior Authorization process.
- Services provided by Molina staff or Molina Providers.

If an Enrollee is unhappy with Molina or its Providers, he/she may file a grievance by contacting Member Services or by writing to:

Molina Healthcare of Illinois, Inc.
Attention Appeals and Grievance
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Fax: (855) 502- 5128

Enrollees are notified of their grievance rights through various general communications including, but not limited to, the Member Handbook, Evidence of Coverage and Disclosure, Member newsletters, and Molina's website.

Enrollees may identify an individual, including an attorney or Provider, to serve as a personal representative to act on their behalf at any stage during the grievance. If, under applicable law, a person has authority to act on behalf of an Enrollee in making decisions related to health care or is a legal representative of the Enrollee, Molina will treat such person as a personal representative. Providers are permitted to submit a grievance on behalf of Enrollee; however, signed consent from the Enrollee is required. Molina will ensure that no punitive action is taken against a Provider who acts as an authorized representative on behalf of the Enrollee or supports a grievance filed by an Enrollee.

When needed, Enrollees are given reasonable assistance in completing forms and taking other procedural steps, including translation services for Enrollees with limited English proficiency or other limitations (e.g., hearing impaired, requiring communication support).

Any grievance or appeal with Potential Quality of Clinical Care (PQCC) is referred to the Quality Improvement (QI) department for documentation and further investigation when appropriate. Additionally, any identified issue related to the privacy and confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

Enrollee Grievance Timelines

An Enrollee may file a grievance at any time. Grievances may be submitted by phone or in writing. When submitted by phone to the Member Services team, the phone call will serve as the acknowledgment of the grievance. When submitted in writing, a written

acknowledgement of the grievance will be sent to the Enrollee within 48 hours of receipt. A determination will be made as expeditiously as possible but no later than 90 days from receipt of the grievance. Molina will provide the Enrollee (or designated representative) a notification of outcome.

Reporting

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

Record Retention

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

15. CREDENTIALING AND RECREDENTIALING

The purpose of the Credentialing Program is to assure that Molina Healthcare and its subsidiaries (Molina) network consist of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure document, which can be requested by contacting your Molina Provider Network Manager.

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 was developed in accordance with state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Nondiscriminatory Credentialing and Recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g. Medicaid) in which the practitioner specializes. This does not preclude Molina from including in its network practitioners who meet certain demographic or specialty needs (e.g., to meet cultural needs of Members).

Types of Practitioners Credentialed & Recredentialed

Practitioners and groups of practitioners with whom Molina contracts must be credentialed prior to the contract being implemented. Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists.
- Addiction medicine specialists.
- Audiologists.
- Behavioral health care practitioners who are licensed, certified, or registered by the state to practice independently.
- Chiropractors.
- Clinical social workers.
- Dentists.
- Doctoral or master's-level psychologists.
- Licensed/certified midwives (non-nurse).
- Massage therapists.
- Master's-level clinical social workers.
- Master's-level clinical nurse specialists or psychiatric nurse practitioners.
- Medical doctors (MD).

- Naturopathic physicians.
- Nurse midwives.
- Nurse practitioners.
- Occupational therapists.
- Optometrists.
- Oral surgeons.
- Osteopathic physicians (DO).
- Pharmacists.
- Physical therapists.
- Physician assistants.
- Podiatrists.
- Psychiatrists and other physicians.
- Speech and language pathologists.
- Telemedicine practitioners.

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the Molina Network. These criteria have been designed to assess a practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing, and ongoing participation in the Molina Provider Network. To remain eligible for participation, practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

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

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

- **Application**—Provider must submit to Molina a complete credentialing application either from CAQH ProView or other state-mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, Certification or Registration**—Provider must hold a current and valid license, certification, or registration to practice in its specialty in every state in which

they will provide care and/or render services for Molina Members. Telemedicine practitioners are required to be licensed in the state where they are located and the state where the Member is located.

- **DEA or CDS Certificate**—Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every state where the Provider provides care to Molina Members. If a practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the practitioner must then provide a documented process that allows another practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number.
- **Specialty**—Providers must only be credentialed in the specialty in which they have adequate education and training. Providers must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education**—Provider must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training**—Providers must have satisfactorily completed residency programs from accredited training programs in the specialties in which they are practicing. Molina only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States, or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three-year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.
- **Fellowship Training**—If Providers are not board certified in the specialty in which they practice and have not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification**—Board certification in the specialty in which the practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:
    - American Board of Medical Specialties (ABMS)
    - American Osteopathic Association (AOA)
    - American Board of Foot and Ankle Surgery (ABFAS)
    - American Board of Podiatric Medicine (ABPM)
    - American Board of Oral and Maxillofacial Surgery

- American Board of Addiction Medicine (ABAM)
- College of Family Physicians of Canada (CFPC)
- Royal College of Physicians and Surgeons of Canada (RCPSC)
- Behavioral Analyst Certification Board (BACB)
- National Commission on Certification of Physician Assistants (NCCPA)

- **General Practitioners**—Practitioners who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a general practitioner in the Molina network. To be eligible, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Molina will consider allowing a practitioner who is/was board certified and/or residency-trained in a specialty other than primary care to participate as a general practitioner, if the practitioner is applying to participate as a Primary Care Physician (PCP), urgent care, or wound care. General practitioners providing only wound care services do not require five years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants**—In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, it would also be required that the practitioner providing the supervision and/or oversight be contracted and credentialed with Molina.
- **Work History**—Provider must supply most recent five-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the practitioner must clarify the gap verbally or in writing. The organization will document a verbal clarification in the practitioner's credentialing file. If the gap in employment exceeds one year, the practitioner must clarify the gap in writing.
- **Malpractice History**—Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance**—Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims and settlement history is requested from the practitioner on the credentialing application. If an affirmative response to the related disclosure questions on the application exists, a detailed response is required from the practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations, and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If an affirmative response to the related disclosure questions on the application exists, a detailed response is required from the practitioner. Molina will also verify all licenses, certifications, and registrations in every state where the

practitioner has practiced. At the time of initial application, the practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[3]. This would include statement of charges, notice of proposed disciplinary action or the equivalent.

- **Medicare, Medicaid and other Sanctions and Exclusions**—Practitioner must not be currently sanctioned, excluded, expelled or suspended from any state- or federally funded program, including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If an affirmative response to the related disclosure questions on the application exists, a detailed response is required from the practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits. If an affirmative response to the related disclosure questions on the application exists, a detailed response is required from the practitioner.
- **Medicare Opt-Out**—Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File**—Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List**—Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance**—Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the practitioner's activities on Molina's behalf. Practitioners maintaining coverage under a federal tort or who are self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform**—Practitioner must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If an affirmative response to the related disclosure questions on the application exists, a detailed response is required from the practitioner.

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

- **Lack of Present Illegal Drug Use**—Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions**—Practitioners must disclose if they have ever had any criminal convictions. Practitioners must never have been convicted, including guilty pleas and adjudicated pretrial diversions for crimes against a person, such as murder, rape, assault, and other similar crimes. At the time of initial credentialing, practitioner must not have any pending criminal charges in these categories:
    - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes.
    - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
    - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
    - Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services, or services that fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes.
- **Loss or Limitations of Clinical Privileges**—At initial credentialing, practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges. If an affirmative response to the related disclosure questions on the application exists, a detailed response is required from the practitioner. At recredentialing, practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges**—Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI**—Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare & Medicaid Services (CMS).

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

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

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

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

- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina.
- In their response, the practitioner must explain the discrepancy, may correct any erroneous information, and may provide any proof that is available.
- The Practitioner's response must be sent to
    - Molina Healthcare, Inc.
      Attention: Credentialing Director
      PO Box 2470
      Spokane, WA 99210

Upon receipt of notification from the practitioner, Molina will document receipt of the information in the practitioner's credentials file. Molina will then reverify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing that the correction has been made to the credentials file. If the primary source information remains inconsistent with the practitioner's information, the Credentialing department will notify the practitioner.

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

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

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

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

The only items in the file that may be copied by the practitioner are documents that the practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to Be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email, or mail. Practitioner's rights are published on the Molina website and are included in this Provider Manual. Molina will respond to the request within two

working days. Molina will share with the practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Notification of Credentialing Decisions

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

Recredentialing

Molina recredentials every practitioner at least every 36 months.

Excluded Providers

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

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

Ongoing Monitoring of Sanctions and Exclusions

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

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program**—Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions**—Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)**—Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.

- **Medicare Preclusion List**—Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database (NPDB)**—Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges, and malpractice history between credentialing cycles.
- **System for Award Management (SAM)**—Monitor for Providers sanctioned with SAM.

Molina also monitors the following for all Provider types between the recredentialing cycles.

- Member complaints/grievances.
- Adverse events.
- Medicare opt-out.
- Social Security Administration death master file.

Provider Appeal Rights

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

16. DELEGATION

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

- Medical management.
- Credentialing and recredentialing.
- Sanction monitoring for employees and contracted staff at all levels.
- Claims.
- Complex case management.
- CMS preclusion list monitoring.
- Other clinical and administrative functions.

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

Delegation Reporting Requirements

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

Corrective Action Plans and Revocation of Delegated Activities

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

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

17. PHARMACY

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our Members with high-quality, cost-effective drug therapy. Molina works with our Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter (OTC) drugs.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T Committee is organized to assist Molina with managing pharmacy resources and to improve the overall satisfaction of Molina Members and Providers. It seeks to ensure Molina Members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy Network

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting MolinaMarketplace.com or calling Molina at **(855) 866-5462**.

Drug Formulary

The pharmacy program does not cover all medications. Molina keeps a list of drugs, devices, and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can obtain from a pharmacy. Some medications require Prior Authorization (PA) or have limitations on age, dosage, and/or quantities. For a complete list of covered medications, please visit the Drug List page of the provider website. You can also visit the Forms page and download the Pharmacy Prior Authorization Form.

Information about procedures to obtain these medications is described within this document and also available on the Drug List page.

Formulary Medications

In some cases, Members may only be able to receive certain quantities of medication. Information on limits are included and can be found in the formulary document.

Formulary medications with PA may require the use of first-line medications before they are approved. Visit the Forms & Documents page of Molina's Marketplace Provider website to and download the Pharmacy Prior Authorization Form.

Quantity Limitations

Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits
Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

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

Non-Formulary Medications
Non-formulary medications may be considered for exception when formulary medications are not appropriate or have proven ineffective for a particular Member. Requests for formulary exceptions should be submitted using a Pharmacy PA form. Clinical evidence must be provided and is taken into account when evaluating the request to determine Medical Necessity. The use of manufacturer's samples of non-formulary or "Prior Authorization Required" medications does **not** override formulary requirements.

Visit the Forms & Documents page and download the Pharmacy Prior Authorization Form.

Generic Substitution
Generic drugs should be dispensed when available. If the use of a particular brand name becomes Medically Necessary as determined by the Provider, PA must be obtained through the standard PA process. Visit the Forms & Documents page and download the Pharmacy Prior Authorization Form.

New-to-Market Drugs
Newly approved drug products will not normally be placed on the formulary during their first six months on the market. During this period, access to these medications will be considered through the PA process. Visit the Forms & Documents page and download the Pharmacy Prior Authorization Form.

Medications Not Covered
Medications not covered by Molina Marketplace are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are **not** part of the benefit. For a complete list of drugs excluded from the plan benefit please refer to the Member's Evidence of Coverage. Visit the Forms & Documents page and download the Pharmacy Prior Authorization Form.

Submitting a Prior Authorization Request

Molina will only process **completed** PA request forms; the following information **must** be included for the request form to be considered complete:

- Member first name, last name, date of birth, and Molina identification number.
- Prescriber first name, last name, NPI, phone number, and fax number.
- Drug name, strength, quantity, and directions of use.
- Diagnosis.

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing, Molina will either fax or call your office to request clinical information be sent in to complete the review. To avoid delays in decisions, complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Medication PA Request form to Molina at **(855) 365-8112**. A blank Pharmacy PA Request form may be obtained by accessing MolinaMarketplace.com or by calling **(855) 866-5462**.

Providers and office staff can review Molina Clinical Criteria and Clinical Policies online to ensure all required information is submitted for review.

Site of Care for Administered Drugs

For Provider-administered drugs that require Prior Authorization, when coverage criteria are met for the medication, a Site of Care policy is used to determine the Medical Necessity of the requested Site of Care. Molina covers injectable and infused medications in an outpatient hospital setting or at a hospital-affiliated infusion suite when the level of care is determined to be Medically Necessary. To review the site of care policy, please visit MolinaMarketplace.com.

Molina may conduct peer-to-peer discussion or other outreach to evaluate the level of care that is Medically Necessary. If an alternate site of care is suitable, Molina may offer the ordering Provider help in identifying an in-network infusion center, physician office, or home-infusion service, and will help the Member coordinate and transition through Case Management.

Member and Provider "Patient Safety Notifications"

Molina has a process to notify Members and Providers regarding a variety of safety issues, which include voluntary recalls, FDA required recalls, and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA®-accredited organization.

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications maybe covered through the

medical benefit using Healthcare Common Procedure Coding System (HCPCS) via paper or electronic medical claim submission.

Molina, during the Utilization Management review process, will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any federal or state regulatory requirements, and the Member-specific benefit plan coverage prior to determination of benefit processing.

If it is determined to be a Pharmacy benefit, Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes, and alcohol swabs) with each prescription at no charge. Please contact your Provider Network Manager with any further questions about the program.

Newly FDA-approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee. "Buy-and-bill" drugs are pharmaceuticals that a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursement.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription policies, which are designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding opioid and pain safety as needed.

Molina is dedicated to ensuring that Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional opioid safety and Substance Use Disorder resources at MolinaMarketplace.com under the Health Resource tab. Please consult with your Provider Network Manager or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

18. ILLINOIS REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

IL-1 Hold Harmless. If the Participating Provider is a hospital, the Participating Provider agrees that in no event, including but not limited to nonpayment by the Payor of amounts due the Participating Provider under the Agreement or this Product Attachment, insolvency of the Payor any breach of the Agreement or this Product Attachment by the Payor, shall the Participating Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Covered Person, persons acting on the Covered Person's behalf (other than the Payor), the employer or group contract holder for Covered Services provided pursuant to the Agreement or this Product Attachment except for the payment of applicable co-payments or deductibles for Covered Service or fees for services not covered by the Payor. The requirements of this clause will survive any termination of the Agreement or this Product Attachment for services rendered prior to such termination, regardless of the cause of such termination. The Covered Persons, the persons acting on the Covered Person's behalf (other than the Payor) and the employer or group contract holder will be third party beneficiaries of this Section. This Section supersedes any oral or written agreement now existing or hereafter entered into between the Participating Provider and the Covered Person, persons acting on the Covered Person's behalf (other than the Payor) and the employer or group contract holder. (215 ILL. COMP. STAT. 125/2-8(a); ILL. ADMIN. CODE § 5421.50(e))

IL-2 Quality Assurance. Each Participating Provider (and any of their or its subcontractors) shall provide, arrange for, or participate in the quality assurance programs mandated by the Health Maintenance Organization Act, as may be amended. (215 ILL. COMP. STAT. 125/2-8(b))

IL-3 Examination by the Director. Each Participating Provider agrees that the Director of Public Health may make an examination concerning the quality of health care services provided under the Agreement and this Product Attachment as often as the Director deems it necessary for the protection of the interest of the people of the State, but not less frequently than once every three (3) years. Each Participating Provider shall submit his, hers or its books and records relating to Health Plan and the Payor to examination and in every way facilitate them. Each Participating Provider acknowledges that, for the purpose of examinations, the Director of Insurance and the Director of Public Health may administer oaths to and examine the principals of the Participating Provider concerning their or its business. (215 ILL. COMP. STAT. 125/5-4)

IL-4 Termination.

IL-4.1 Each Participating Provider shall provide at least sixty (60) days' notice to Health Plan for termination of the Agreement or the termination of its, their participation under this Product Attachment with cause, as may be defined in the Agreement or Provider Manual, and at least ninety (90) days' notice to Health Plan for termination of the Agreement or the termination of its, their participation under this Product Attachment without cause. (ILL. ADMIN. CODE § 5421.50(a)(5))

IL-4.2 Health Plan shall provide at least sixty (60) days' notice to the Participating Provider of the nonrenewal or termination of the Agreement or its, their participation under this Product Attachment. Notwithstanding the foregoing, immediate written notice of non-renewal or termination may be provided by Health Plan without sixty (60) days' notice if the Participating Provider's license has been disciplined by a State licensing board. (215 ILL. COMP. STAT. 134/20)

IL-4.3 Each Participating Provider acknowledges that notification procedures for termination of the Agreement or this Product Attachment are set forth in the Agreement, this Product Attachment and the Provider Manual. Each Participating Provider agrees that such termination provisions require: (a) not less than thirty (30) days prior written notice by either party who wishes to terminate the Agreement without cause; (b) Health Plan may immediately terminate the Agreement for cause (except as otherwise expressly required by IL-4.1); and (c) if the Participating Provider acts as a primary care physician under a Coverage Agreement requiring a gatekeeper option, the Participating Provider must provide the Payor with a list of all Covered Persons using such Participating Provider as a gatekeeper within five (5) working days after the date that the Participating Provider either gives or receives notice of termination. (ILL. ADMIN. CODE § 2051.290(f))

IL-5 Provider Responsibility. Each Participating Provider acknowledges that the specific Covered Services for which the Participating Provider will be responsible, including any discount services, copayments, benefit maximums, limitations and exclusions, as well as any discount amount or discounted fee schedule reflecting discounted rates, are set forth in the Agreement (which includes the Provider Manual and all Attachments). (ILL. ADMIN. CODE § 2051.290(a))

IL-6 Administrative Policies. Each Participating Provider shall comply with applicable administrative policies and procedures of Health Plan and the Payor including, but not limited to credentialing or recredentialing requirements, utilization review requirements and referral procedures. (ILL. ADMIN. CODE § 2051.290(b))

IL-7 Records. When payments are due to the Participating Provider for services rendered to a Covered Person, the Participating Provider must maintain and make medical records available: (a) to the Payor for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to Covered Persons; (b) to appropriate State and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating member grievances or complaints; and (c) to show compliance with the applicable State

and federal laws related to privacy and confidentiality of medical records. (ILL. ADMIN. CODE § 2051.290(c))

IL-8 Licensure. Each Participating Provider shall be licensed by the State, and notify Health Plan immediately whenever there is a change in licensure or certification status. (ILL. ADMIN. CODE § 2051.290(d))

IL-9 Admitting Privileges. If the Participating Provider is a physician, the Participating Provider shall have admitting privileges in at least one hospital with which Health Plan has a written provider contract. Health Plan shall be notified immediately of any changes in privileges at any hospital or admitting facility. Each Participating Provider acknowledges that Health Plan may make reasonable exceptions for a Participating Provider who, because of the type of clinical specialty, or location or type of practice, does not customarily have admitting privileges. (ILL. ADMIN. CODE § 2051.290(e))

IL-10 Continuity of Care.

IL-10-1 Each Participating Provider agrees to accept the responsibilities for continuation of Covered Services in the event of termination of the Agreement, to the extent that an extension of benefits is required by law or regulation, or that continuation is voluntarily provided by the Payor. (ILL. ADMIN. CODE § 2051.290(g))

IL-10-2 Except in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board, each Participating Provider shall continue to provide Covered Services to Covered Persons in an ongoing course of treatment with that Participating Provider for a transitional period following termination or non-renewal of the Agreement or the termination of the Participating Provider's participation under this Product Attachment: (a) for ninety (90) days from the date of the notice to the Covered Person of the termination or non-renewal of the Agreement or the termination of the Participating Provider's participation under this Product Attachment if the Covered Person has an ongoing course of treatment; or (b) if the Covered Person has entered the third trimester of pregnancy at the time of the termination or non-renewal, through delivery and the provision of postpartum care directly related to the delivery. For transitional periods exceeding thirty (30) days, each Participating Provider agrees: (a) to continue to accept reimbursement from the Payor at the rates applicable prior to the start of the transitional period; (b) to adhere to the Payor's quality assurance requirements and to provide to the Payor necessary medical information related to such care; and (c) to otherwise adhere to the Payor's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorization's for treatment. (215 ILL. COMP. STAT. 134/25)

IL-11 Assignment. The rights and responsibilities under the Agreement or this Product Attachment cannot be sold, leased, assigned, assumed or otherwise delegated by either party without the prior written consent of the other party. By participating under this Product Attachment, Provider and each Participating Provider is hereby deemed to consent to any assignment or assumption of the Agreement or this Product Attachment by Health Plan, including any assignment or assumption in connection with any

purchase of Health Plan by another administrator or insurer. The parties acknowledge that any assignee must comply with all the terms and conditions of the documents being assigned, including all appendices, policies and fee schedules. (ILL. ADMIN. CODE § 2051.290(h))

IL-12 Insurance. Each Participating Provider has and will maintain adequate professional liability and malpractice coverage, through insurance, self-funding, or other means satisfactory to Health Plan. The Participating Provider shall give Health Plan at least fifteen (15) days advance notice of cancellation of such insurance, and shall notify Health Plan within no less than ten (10) days after the Participating Provider's receipt of notice of any reduction or cancellation of the required coverage. (ILL. ADMIN. CODE §§ 5421.50(a)(7); 2051.290(i))

IL-13 Non-Discrimination. Each Participating Provider shall provide health care services without discrimination against any beneficiary on the basis of participation in a Coverage Agreement, source of payment, age, sex, ethnicity, religion, sexual, health status or disability. (ILL. ADMIN. CODE § 2051.290(j))

IL-14 Financial Responsibility. Each Participating Provider shall collect applicable copayments, coinsurance and/or deductibles (if any) from Covered Persons as provided by the Covered Person's Coverage Agreement, and shall provide notice to Covered Persons of their personal financial obligations for services that are not Covered Services including any amount of applicable discounts or, alternatively, a fee schedule that reflects any discounted rates. (ILL. ADMIN. CODE § 2051.290(k))

IL-15 Availability. Except as otherwise provided in the Provider Manual, each Participating Provider shall provide Covered Services on a twenty-four (24) hour per day, seven (7) day per week basis. (ILL. ADMIN. CODE § 2051.290(l))

IL-16 Payment. Each Participating Provider acknowledges that a clear description of the Payor's payment obligations to the Participating Provider are set forth in the Agreement and this Product Attachment, which includes the Compensation Schedule attached at Exhibit 1. (ILL. ADMIN. CODE § 2051.290(m))

IL-17 Information. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) provides a description of the administrative services, if any, the Health Plan or Payor will perform and the types of information (e.g., financial, enrollment, utilization) that will be submitted to the Participating Provider, as well as other information that is accessible to the Participating Provider. (ILL. ADMIN. CODE § 2051.290(n))

IL-18 Benefit Information. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) identifies the method that Participating Providers may use to access Health Plan, each Payor, or their designees to obtain benefit information and adequate notice of change in benefits and copayments. Health Plan will arrange for each Payor's operational policies to be accessible to the Participating Provider. (ILL. ADMIN. CODE § 2051.290(o))

IL-19 Dispute Resolution. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) sets forth the applicable internal appeal or arbitration procedures for settling contractual disputes or disagreements between the Participating Provider and the Health Plan. (ILL. ADMIN. CODE § 2051.290(p))