

PROVIDER MANUAL

(Provider Handbook)

Molina Healthcare of Washington, Inc.

(Molina Healthcare or Molina)

Apple Health (Medicaid) and Apple Health Expansion (AHE)

2026

Capitalized words or phrases in this Provider Manual shall have the meaning outlined in your Agreement with Molina Healthcare. "Molina Healthcare" or "Molina" has the same meaning as "Health Plan" in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated: 01/2026

MHW Part # 0120-0501
MHW: 01/05/26

TABLE OF CONTENTS

1. CONTACT INFORMATION

Molina Healthcare of Washington, Inc.
PO Box 4004
Bothell, WA 98041-4004

Provider Services

The Molina Provider Support Center handles telephone inquiries from Providers regarding claims, appeals, authorizations, eligibility, and general concerns. Molina Provider Support Center representatives are available Monday through Friday, 7:30 a.m. to 6:30 p.m. (PST), excluding state and federal holidays.

Molina strongly encourages Participating Providers to submit Claims electronically (via a clearinghouse or the Availity Essentials portal whenever possible.

EDI Payer ID Number: 38336

To verify the status of your Claims, please use the Availity Essentials portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity Essentials portal or by contacting the Molina Provider Support Center.

Eligibility verifications can be conducted via the Eligibility and Benefits module Availity Essentials Portal.

Availity Essentials portal: provider.MolinaHealthcare.com
Phone: (855) 322-4082
Hearing Impaired (TTY/TDD): 711

Provider Relations

The Provider Relations department manages Provider inquiries regarding issue resolution, provider education, and training. Its representatives serve all of Molina's Provider network.

To find your Provider Relations representative, please visit the Contact Us section of our website at www.molinahealthcare.com/providers/wa/medicaid/contacts/contact_info.aspx

Member Services

The Member Contact Center department handles all telephone and written inquiries regarding benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care

Providers (PCPs), and Member complaints. Member Contact Center representatives are available 7:30 a.m. to 6:30 p.m. Monday through Friday, excluding state holidays.

Phone: (800) 869-7165
TTY/TDD: 711

Claims

Molina strongly encourages Participating Providers to submit Claims electronically via a clearinghouse or the Availity Essentials portal whenever possible.

- Availity Essentials portal at provider.MolinaHealthcare.com
- EDI Payer ID 38336

To verify the status of your Claims, please use the Availity Essentials portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity Essentials portal or by contacting the Provider Contact Center.

Provider Information Team

The Provider Information team should be contacted for demographic updates such as new billing or service location addresses, TIN changes, adding a provider to a group that does not require credentialing, and individual provider and group terminations.

Please email the appropriate form below for demographic updates to MHWProviderInfo@MolinaHealthcare.com:

Provider Change Form: molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/wa/Medicaid/forms/MHW-Provider-ChangeForm.pdf

Termination Notification Form: molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/wa/Medicaid/forms/Termination-NotificationForm.pdf

Claims Recovery

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

Provider Disputes	Molina Healthcare of Washington PO Box 2470 Spokane, WA 99210-2470
Refund Checks Lockbox	Molina Healthcare of Washington PO Box 30717 Los Angeles, CA 90030-0717
Phone	(866) 642-8999
Fax	(888) 396-1520

Compliance and Fraud Alertline

Suspected fraud, waste, or abuse cases must be reported to Molina. You may contact the Molina Alertline or submit an electronic complaint using the website listed below. For additional information on fraud, waste, and abuse, please refer to the Compliance section of this Provider Manual.

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

Phone: (866) 606-3889
Online: MolinaHealthcare.alertline.com

Credentialing

The Credentialing department verifies all information on the Provider Application before contracting and re-verifies this information every three (3) 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. For additional details about Molina's Credentialing program, including Policies and Procedures, please refer to this Provider Manual's Credentialing and Recredentialing section.

Please send inquiries to our contracting/credentialing team at MHWProviderInfo@molinahealthcare.com

24-Hour Nurse Advice Line

This telephone-based Nurse Advice Line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week.

Phone: (888) 275-8750
TTY/TDD: 711 Relay

Health Care Services

The Health Care Services (HCS) department reviews inpatient cases concurrently and processes Prior Authorizations/Service Requests. The Health Care Services (HCS) department also performs Care Management for Members who will benefit from Care Management services. Participating Providers must interact with Molina's HCS department electronically when possible. Prior Authorizations/Service Requests and status checks can be easily managed electronically.

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

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

Molina offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Molina via the Availity Essentials portal.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Availity Essentials portal: provider.MolinaHealthcare.com
- Prior Authorization Phone: (800) 869-7175
- Prior Authorization Fax Medical: (800) 767-7188
- Prior Authorization Behavioral Services Fax: (833) 552-0030
- Transplant Fax: (877) 813-1206
- Advanced Imaging Fax: (877) 731-7218

Exception: *If the Member's PCP belongs to a delegated medical group/Independent Practice Association (IPA), the Provider should contact that medical group/IPA for Authorization guidance.*

Behavioral Health

Molina manages all components of Covered Services for behavioral health. For Member behavioral health needs, please contact us directly at (888) 275-8750 (English) or (866) 648-3537 (Spanish). 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 Member ID card. For additional information, please refer to the **Behavioral Services** section of this Provider Manual.

Pharmacy

Prescription drugs are covered through any contracted pharmacy. A list of in-network pharmacies is available on the MolinaHealthcare.com website or by contacting Molina. For additional information, please refer to the **Pharmacy** section of this Provider Manual.

Phone: (855) 322-4082

Vision Service Plan (VSP®)

Molina is contracted with VSP® to provide routine vision services for our Members. Eligible members may directly access a VSP® Network Provider.

Phone: (800) 615-1883

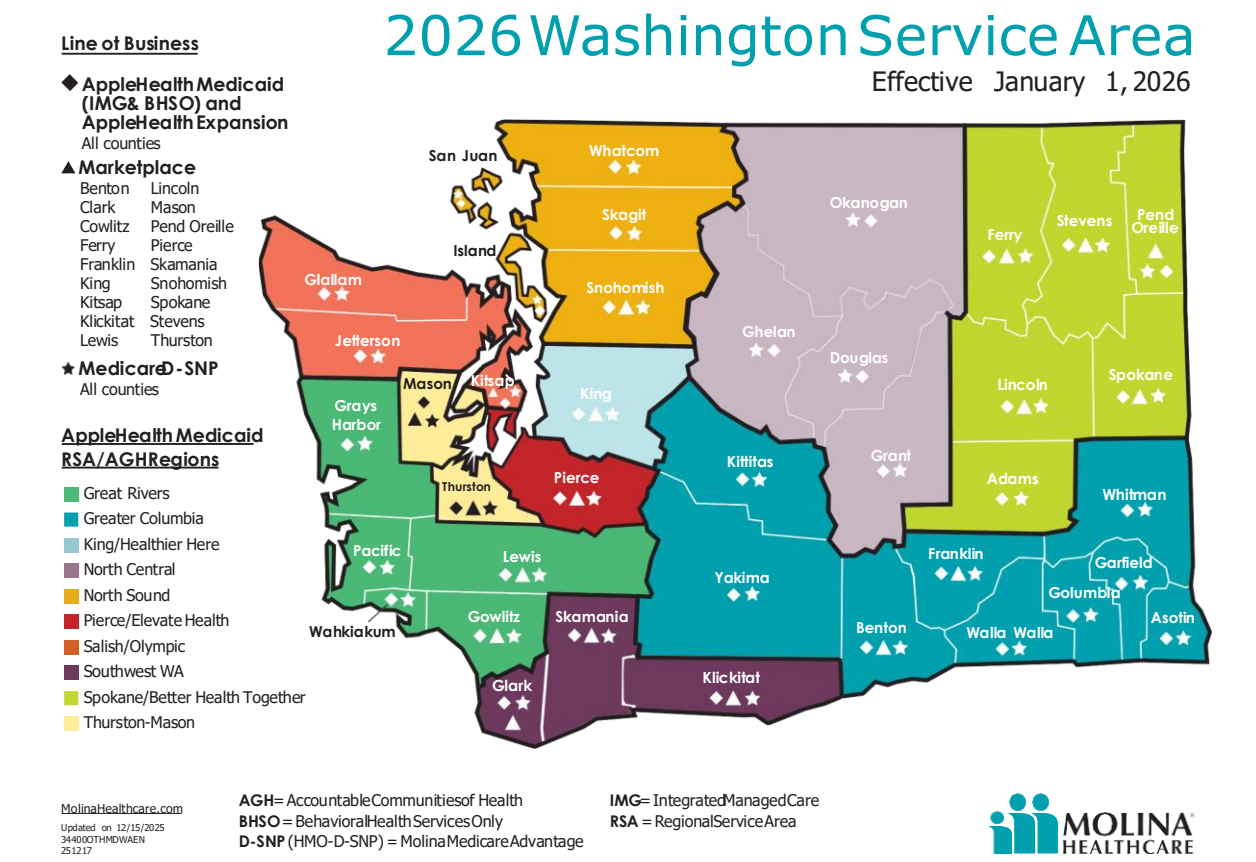
EXCEPTION: *If the Member's PCP belongs to a delegated medical group or IPA, the Provider should contact that medical group or IPA for Authorization guidance.*

Quality

Molina maintains a quality department that works with members and providers to administer the Molina Quality Program.

Email: MHW_QI_Department@Molinahealthcare.com
Voicemail: (866) 325-5173
Fax: (800) 461-3234

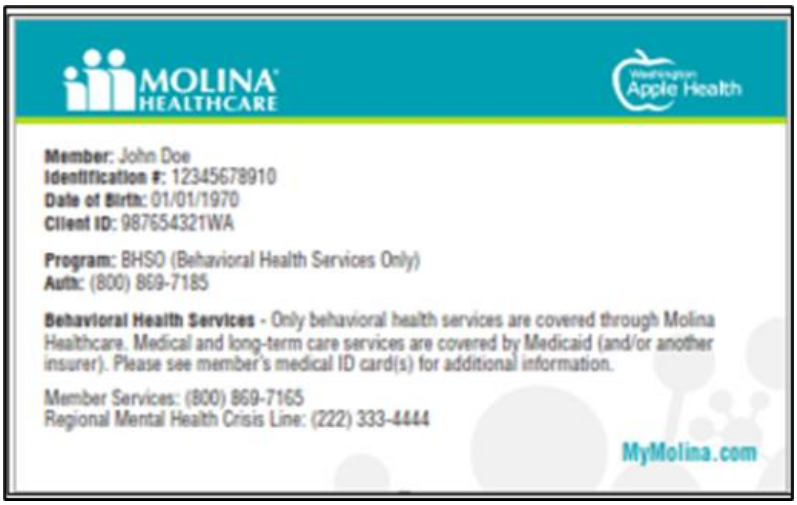
Molina Healthcare of Washington Service Area



Molina Healthcare of Washington Identification Cards

Apple Health & Apple Health Expansion

Behavioral Health Services Only (BHSO)



2. PROVIDER RESPONSIBILITIES

Nondiscrimination in Health Care Service Delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as outlined in the **Culturally and Linguistically Appropriate Services** section of this Provider Manual.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to the source of payment. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost-sharing from a government-funded program. Providers serving Medicaid Members are required to maintain the same hours of operation as those offered to commercial benefit Members.

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

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

For additional information, you can refer to the Department of Health and Human Services website at federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-ofauthority.

Facilities, Equipment, and administrative services

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

Providers must ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Members and Provider Network. Maintaining an accurate and current Provider Online Directory is a state and federal regulatory requirement and a National Committee for Quality Assurance (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.

Please visit our Provider Online Directory at Home (sapphirethreesixtyfive.com) to validate your information. Providers must validate their Provider information on file with Molina at least once every 90 days for correctness and completeness.

Additionally, in accordance with the terms specified in your Provider Agreement, Providers must notify Molina of any changes as soon as possible, but at a minimum of 30 calendar days in advance, to Provider information on file with Molina. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition of a Provider (within an existing clinic/practice).
- Change in Provider or practice name, Tax ID, and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (PCPs only).
- Change in specialty.
- 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.

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 Online 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 Online Directory or otherwise impacts membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

All Molina Providers participating in a Medicaid network must be enrolled in the state Medicaid program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with the Washington Health Care Authority

and meet the Medicaid Provider enrollment requirements set forth on the website at www.hca.wa.gov/billers-providers-partners/become-apple-health-provider/enroll-provider for fee-for-service Providers of the appropriate provider type

National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, CMS recommends that Providers routinely verify and attest to the accuracy of their NPPES data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider can attest, and NPPES will reflect the attestation date. If the information is incorrect, the Provider can request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages our Provider Network to verify Provider data via nppes.cms.hhs.gov. Molina may validate the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data. 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.

National Provider Identifier (NPI) HCA Billing and Non-Billing Enrollment Requirements

Per federal regulation (42.C.F.R. 455.410(b)), providers who have a contract with the state's Medicaid agencies or contracts with Managed Care Organizations (MCOs) that serve Medicaid Clients must enroll with the Washington State Health Care Authority (HCA) under a Non-Billing or Billing agreement. The provider's National Provider Identifier (NPI) submitted on all claims must be the NPI registered with HCA.

Molina will deny/reject all claims submitted for processing if they are billed with an NPI that is not enrolled with HCA or does not match what HCA identifies as the enrolled NPI number.

For additional information and to access the Non-Billing and Billing and servicing enrollment form, which must be used to register with HCA or to correct an NPI, visit the HCA website at hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/enroll-provider.

Molina electronic solutions requirements

Molina strongly encourages 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 Availity Essentials portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the Availity Essentials 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 Availity Essentials 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 Molina Healthcare of Washington

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- Availity Essentials portal

Electronic Claim submission requirement

Molina strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claim 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 Availity Essentials portal.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 38336. For additional information, refer to our website, Molina Healthcare of Washington.
- While both options are embraced by Molina, submitting Claims via the Availity Essentials portal (available to all Providers at no cost) offers several additional Claim processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.
- Availity Essentials portal Claims submission includes the ability to:
    - Submit Claims through direct data entry
    - Add attachments to Claims.
    - Submit Claims through quick Claims entry and saving templates
    - Submit corrected Claims.
    - Add attachments to corrected claims
    - Add attachments to pending claims
    - Easily and quickly void Claims.
    - Check Claim status.
    - Receive timely notification of a change in status for a particular Claim.
    - Ability to Save incomplete/un-submitted Claims.
    - Create/Manage Claim Templates.

For additional information on EDI Claims submission and Paper Claims submission, please refer to the **Claims and Compensation** section of this Provider Manual.

Electronic payment requirement

Participating Providers are strongly encouraged to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment, and

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

Molina has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform, you may receive your payment via EFT/Automated Clearing House (ACH), a physical check, or a virtual card.

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

If you would like to opt-out of receiving a Virtual Card prior to your first payment, you may contact Molina and request that your Tax ID for payer Molina Healthcare of Washington be opted out of Virtual Cards.

Once you enroll for electronic payments, you will receive the associated ERAs from ECHO with the Molina Payer ID. Please ensure that your practice management system is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO provider portal at providerpayments.com.

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

As a reminder, Molina's Payer ID is 38336.

Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper explanation of payment (EOP) (i.e., remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download, and save historical and new ERAs with a two-(2)-year lookback.

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

Availity Essentials portal

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

- Verify Member eligibility, and covered services, and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps)
- Claims:
  - Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) Claims with attached files
  - Correct/Void Claims
  - Add attachments to previously submitted Claims.
  - Check Claims status.
  - View ERA and EOP
  - Create and manage Claim Templates
  - Submit and manage Claim disputes, including formal appeals or reconsideration requests, for finalized Claims
  - View, dispute, resolve Claim overpayments
- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization/Service Requests
  - Check the status of Authorization/Service Requests
  - Access prior authorization letters directly through the new DC Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.
- Download forms and documents.
- Send/receive secure messages to/from Molina.
- Manage Overpayment invoices (Inquire, Dispute and Resolve)

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Provider network management portal: enrollment tool

The **Provider Network Management Portal** is a secure, free tool used to manage Provider enrollment and credentialing requests. All credentialing requests for a Provider to join the network must be submitted electronically through the portal.

Available functions include:

- Adding practitioners to an existing group
- Submitting credentialing requests
- Tracking credentialing and participation status
- Providing additional or missing information for enrollment or credentialing
- Uploading provider rosters
- Adding new facility locations

Access

Office managers, administrative personnel, or Providers who need access to the portal for the first time must submit a registration request directly through the Provider Network Management Portal at Molina/ProviderManagement.

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 Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

Member rights and responsibilities

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

For more 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 compliance with all state and federal laws and regulations. Any written information or marketing materials directed to Molina members that reference Molina must be approved by Molina prior to use.

Please contact your Provider Relations representative for information on the review process of proposed materials.

Member eligibility verification

Possession of a Molina ID card does not guarantee Member eligibility or coverage. Providers should verify the 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:

- Availity Essentials portal at provider.MolinaHealthcare.com
- Molina Provider Services automated Interactive Voice Response (IVR) system at (855) 322-4082

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

Healthcare 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 more information, please refer to the Health Care Services section of this Provider Manual.

In-office laboratory tests

Lab testing should be referred to an In-Network Laboratory Provider, a certified, full-service laboratory offering a comprehensive test menu that includes routine, complex, drug, genetic, and pathology testing.

Additional information regarding Molina's preferred In-Network Laboratory provider-patient service centers is found here: appointment.questdiagnostics.com/patient/confirmation.

Referrals

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

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers 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 rooms. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Molina, except in the case of Emergency Services.

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

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

Treatment alternatives and communication with Members

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

Pharmacy Program Providers are required to adhere to Molina's drug formularies and prescription policies. For additional information please refer to the Pharmacy section of this Provider Manual.

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 Improvement (QI) Programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer reviews 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.

PCP Role in Screening, Identifying, Intervening, and Referring Members for Mental Health and Substance Use Disorder Services

It is the primary care provider's (PCP) responsibility to routinely screen Members to assess whether they have any Mental Health (MH) or Substance Use Disorder (SUD) symptoms. If the results of the assessment indicate MH or SUD symptoms, the PCP is responsible for providing treatment or referring the Member to the appropriate mental health or substance use disorder services, taking into consideration the Member's motivation and interest in obtaining care. Providers can reference the Molina Provider Online Directory for in-network behavioral health providers. PCP's should support and encourage the Member toward reduction in symptoms related to MH or SUD to improve health outcomes and to support recovery. PCPs should educate members about the benefits of treating BH conditions and the risks if not treated.

Information on whole person care, the principles of recovery and provider strategies to support recovery can be found at samhsa.gov/resource-search/ebp as well as through the University of WA AIMS Center website at aims.uw.edu. Additional information pertaining to substance use disorder can be found at asam.org. For additional information about advancing your clinic's ability to provide integration of behavioral health and general health care, consult the Washington Integrated Case Assessment (WA-ICA) at waportal.org/partners/home/WA-ICA. Please contact your assigned Provider Services representative if you are interested in additional resources to support this work with our Members.

Behavioral Health Screening and Assessment

All behavioral health providers should consistently utilize standardized and widely recognized measurement tools when screening for behavioral health conditions and co-occurring conditions. Employing validated instruments ensures accuracy, promotes consistency across care settings, and supports evidence-based decision-making. Standardized screening not only improves early identification and treatment planning but also enhances communication among providers and aligns with best practices for quality care delivery.

Behavioral Health Telehealth Providers

Molina works with several behavioral health telehealth providers that can be located at the Molina Healthcare website.

Referral for Mental Health Services

Molina covers lower-intensity outpatient MH services for mild-to-moderate MH conditions, including psychotherapy, psychological testing, and medication management, as well as higher-intensity MH services (such as residential or inpatient treatment) for Medicaid and Apple Health Expansion members. Members may also self-refer to MH services. Please see the Molina

Provider Online Directory (POD) or contact our Molina Member Services for a list of participating mental health providers.

Wraparound with Intensive Services (WISe) Providers

WISe providers are required to follow the program, policies, and procedures contained within the Department of Social and Health Services (DSHS) Wraparound with Intensive Services (WISe) Manual, which is available at hca.wa.gov/assets/billers-and-providers/wisewraparound-intensive-services-manual.pdf. WISe providers must participate in all WISe-related quality activities including but not limited to conducting or participating in a review of WISe services using the WISe Quality Improvement Tool (QIRT) at least once annually.

WISe providers are required to send Molina a notification of any adverse benefit determination (ABD) indicated in the WISe manual within 24 hours of the ABD determination. The WISe Notification form can be found under "Other" at: MolinaHealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx.

Referral for Substance Use Disorder (SUD)

Molina covers SUD treatment services, including outpatient services, case management, opiate substitution treatment, medication-assisted treatment, and inpatient/residential treatment. Members may also self-refer to SUD treatment services. Please see the Molina Provider Online Directory (POD) or contact our Molina Member Services, for a list of participating SUD providers.

Compliance

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

Confidentiality of Member health information and HIPAA transactions

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

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

CFR 42 Part 2

Molina requires Providers to comply with C.F.R. 42 Part 2, which relates to the privacy of all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance use disorder program that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.

- Molina Healthcare is committed to working with its providers to address the care coordination and care management needs of its members.
- To facilitate such activities, all providers (including SUD providers and other behavioral health providers) are required to cooperate with and provide to Molina Healthcare any, and all relevant patient/member records and information requested by Molina Healthcare to support such activities.
- To the extent consent and/or authorization from the patient/member is required by law to disclose the requested records/information to Molina Healthcare, the provider shall take reasonable steps to obtain the necessary consent(s) and/or authorization(s) from the patient/member.

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 ten (10) years and retained further if the records are under review or audit until such time that the review or audit is complete.

For more information, please refer to the Provider Dispute Resolution and Member Appeals section of this Provider Manual.

Participation in credentialing

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

Please refer to the Credentialing and Recredentialing section of this Provider Manual for additional information on Molina's credentialing program, including policies and procedures.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegated Services Addendum. For additional information on Molina's delegation requirements and delegation oversight, please refer to the **Delegation** section of this Provider Manual.

Primary Care Provider (PCP) responsibilities

PCPs are responsible to:

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

Ensuring Compliance with Washington State Background Check Requirements

In accordance with state law, Providers are required to submit their Practitioners, employees, volunteers, and/or Subcontractor staff who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults, as defined by RCW 43.43.830(14), to a criminal history background check through the Washington State Patrol at wsp.wa.gov/crime/criminal-history/.

Such criminal history background check shall be consistent with RCW 43.43.832, RCW 43.43.834, RCW 43.20A.710, chapter 388-06 WAC, and any other applicable statute or regulation.

The Provider shall not allow Practitioners, employees, volunteers, and/or Subcontractor staff to access children and/or vulnerable adults until a criminal history background check is performed and a positive result is reported.

3. CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Background

Molina works to ensure all Members receive culturally and linguistically appropriate care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), seek to improve the appropriateness and accessibility of health care services by meeting the cultural, linguistic, and accessibility related needs of individuals served. Molina complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance based on race, color, national origin, sex, age, and disability per Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities Act of 1990. Molina also complies with all implementing regulations for the foregoing. 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, sexes, 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 culturally and linguistically appropriate services is available on the Availity Essentials portal (Go to Payer spaces, Resources Tab), from your local Provider Services representative, and by calling Molina Provider Support Center at (855) 322-4082.

Nondiscrimination in Health Care Service Delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR), state law; and federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need for frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found at https://www.molinahealthcare.com/members/wa/en-us/-

/media/Molina/PublicWebsite/PDF/members/wa/en-us/Medicaid/Molina-Healthcare-Notice-1557---WA-Medicaid.pdf

3. You **MUST** post in a conspicuous location in your office a Tagline Document that explains how to access non-English language services at no cost. A sample of the Tagline Document that you will post can be found at https://www.molinahealthcare.com/members/wa/en-us/-/media/Molina/PublicWebsite/PDF/members/wa/en-us/Medicaid/Molina-Healthcare-Notice-1557---WA-Medicaid.pdf
4. If a Molina Member is in need of accessibility-related services, you MUST provide reasonable accommodation for individuals with disabilities and appropriate auxiliary aids and services
5. If a Molina Member needs language assistance services while at your office, and you are a recipient of federal financial assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP"). You can find resources on meeting your LEP obligations at Limited English Proficiency (LEP) | HHS.gov and Limited English Proficiency Resources for Effective Communication | HHS.gov.
6. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone (866) 606-3889 TTY/TDD, 711 civil.rights@MolinaHealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website: ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Form: hhs.gov/ocr/complaints/index.html

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

Culturally and linguistically appropriate practices

Molina is committed to reducing health care disparities and improving health outcomes for all Members. Training employees, Providers, and their staff and improving appropriateness and accessibility are the cornerstones of assessing, respecting, and responding to a wide variety of cultural, linguistic and accessibility needs when providing health care services. Molina integrates culturally and linguistically appropriate practices training into the overall Provider

training and quality-monitoring programs. An integrated quality approach enhances the way people think about our Members, service delivery, and program development so that culturally and linguistically appropriate practices become a part of everyday thinking.

Provider and Community Training

Molina offers educational opportunities in culturally and linguistically appropriate practices and concepts for Providers and their staff,. Molina conducts Provider training during Provider orientation, with annual reinforcement training offered through Provider Services and/or online/web-based training modules. Web-based training modules can be found on the Availity Essentials portal.

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

1. Provider written communications and resource materials.
2. Online culturally and linguistically appropriate practices Provider training modules.
3. Integration of culturally and linguistically appropriate practices concepts and nondiscrimination of service delivery into Provider communications.

Integrated Quality Improvement

Molina ensures Member access to language services such as oral interpretation, American Sign Language (ASL), written materials in alternate formats, 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 of 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 MolinaHelathcare.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.

Access to Language Services: Medicaid and BHSO Members

The following guidance on Interpreter Services applies to Medicaid and BHSO Members only.

Providers may request interpreters for Members who speak a language other than English, including ASL, by calling Molina's Member and Provider Support Center toll-free at (800) 869-7165. If Member and Provider Support Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified interpreter.

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend, or minor to interpret.
All eligible Members who are Limited English Proficient (LEP) are entitled to receive language services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency (LRP), or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist providers with locating these services if needed.

An individual with LEP is an individual whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English well enough to understand and communicate effectively (whether because of language, cognitive, or physical limitations). It is possible that an individual with LEP may be able to speak or understand English but still be limited to read or write in English. It is also important to not assume that an individual who speaks some English is proficient in the technical vocabulary of the health care services required.

Molina Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Be given access to Care Managers trained to work with individuals with cognitive impairments.
- Be notified by the medical Provider that interpreter services, including ASL, are available at no cost
- Be given reasonable accommodations, appropriate auxiliary aids and services
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
    - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records.
    - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf.
    - Interpreters must ensure that this shared information is similarly safeguarded.
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

Interpreters include people who can speak the Member's primary language, assist with a disability, or help the Member understand the information.

When Molina Members need an interpreter, limited hearing, and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing, and/or limited reading services are available.

Interpreter Services (IS) for pre-scheduled appointments are available through the Health Care Authority (HCA) for Medicaid health care professionals to gain access to skilled and qualified spoken and sign language interpreters for Apple Health (Medicaid) clients who require access to quality, efficient language during their health care services. More information on HCA's coverage of IS for Medicaid members can be found at hca.wa.gov/billers-providerspartners/program-information-providers/interpreter-services-providers.

Molina is also available to assist Providers with locating interpreter services if needed. Molina can assist providers with:

- Finding onsite, video remote, or telephonic interpreter services.
- Obtaining written materials in preferred languages
- Providers with Members who cannot hear or have limited hearing ability may use TTY/TDD at 711.
- Providers with Members with limited vision may contact Molina for documents in large print, braille, or audio version.
- Providers with Members with limited reading proficiency (LRP). The Molina Member Support Center representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

Access to Language Services: Apple Health Expansion (AHE) Members

The following guidance on Interpreter Services applies to Apple Health Expansion (AHE) Members only.

Providers may request interpreters for Members who speak a language other than English, including ASL, by calling Molina's Member and Provider Support Center toll-free at (800) 869-7165. If Member and Provider Support Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified interpreter.

Molina Providers must support AHE Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may

offer Molina Members interpreter services if the Members do not request them independently. Please remember it is never permissible to ask a family member, friend, or minor to interpret.

All eligible AHE Members who are Limited English Proficient (LEP) are entitled to receive language services. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist providers with locating these services.

An individual with LEP is an individual whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English well enough to understand and communicate effectively (whether because of language, cognitive, or physical limitations). It is possible that an individual with LEP may be able to speak or understand English but still be limited to read or write in English. It is also important to not assume that an individual who speaks some English is proficient in the technical vocabulary of the health care services required.

Molina Members are entitled to:

- Be provided with effective communication with medical Providers.
- Be given access to Care Managers trained to work with individuals with cognitive impairments.
- Be notified by the medical Provider that interpreter services, including ASL, are available at no cost.
- Be given reasonable accommodations, appropriate auxiliary aids and services
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality as follows:
    - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records.
    - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf.
    - Interpreters must ensure that this shared information is similarly safeguarded.
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

Interpreters include people who can speak the Member's primary language, assist with a disability, or help the Member understand the information.

When Molina Members need an interpreter, limited hearing, and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.

- Inform the Member that an interpreter, limited hearing, and/or limited reading services are available.

For the Apple Health Expansion Program, Interpreter Services (IS) for pre-scheduled appointments are available through Managed Care for Medicaid health care professionals. Molina AHE Members are eligible for IS services through Globo. For more information on accessing IS services for AHE Members please call: (855) 322-4082.

Documentation

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

- Record the Member's language preference in a prominent location in the medical record. This information is provided 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

The TTY/TDD connection can be reached by dialing 711. This connection provides access to the Member & Provider Support 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. These devices enhance the sound of the Provider's voice to facilitate better interaction with the Member.

Molina will provide on-site or video service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made at least three (3) business days in advance of an appointment to ensure the availability of the service. In most cases, Members will have made this request via the Molina Member Support Center.

24-Hour Nurse Advice Line

Molina provides Nurse Advice services for Members 24 hours per day, 7 days per week. The

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

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity, and language data from:
    - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
    - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider network and cultural responsiveness
- Collection of data and reporting for the Race/Ethnicity Description 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 across the plan's diverse populations.
- Analysis of HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventative services.

4. MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website.

The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Apple Health (Medicaid) Member Handbook can be found on the Member pages of Molina's website at www.molinahealthcare.com/members/wa/en-us/mem/medicaid/imc/member-handbook.aspx.

The most current Behavioral Health (BHSO) Member Handbook can be found on the Member pages of Molina's website at www.molinahealthcare.com/members/wa/en-us/mem/medicaid/bhso/member-handbook.aspx

The most current Member Rights and Responsibilities can be found on the Member pages of Molina's website at www.molinahealthcare.com/members/wa/en-us/mem/medicaid/imc/quality/member-rights.aspx. Member Rights and Responsibilities are outlined under the heading "Your Rights and Responsibilities", 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 or health care facility's right to expect certain behavior on the part of the Members.

For additional information please contact the Molina Provider Support Center at (855) 322-4082, Monday through Friday, 7:30 a.m. to 6:30 p.m. (PST), TTY/TDD: users, please call 711 for persons with hearing impairments.

Second opinions

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

5. ELIGIBILITY, ENROLLMENT, DISENROLLMENT

Enrollment

Enrollment in Washington Apple Health Integrated Managed Care (IMC) Medicaid, Behavioral Health Services Only (BHSO), and Apple Health Expansion (AHE) programs

Molina Members are enrolled in a managed care health plan after the Health Care Authority (HCA) determines a Member is eligible for services through Apple Health Medicaid or the Apple Health Expansion (AHE) Program. To enroll with an Apple Health Program (IMC,BHSO, or AHE) their representative or responsible parent/guardian must apply online at wahealthplanfinder.org or call the Customer Support Center at (855) WAFINDER (855-923-4633) or (855) 627-9604 (TTY 711) where they can choose Molina as their health plan. Once a Member is eligible for Medicaid or AHE they may change their health plan up to once per month. Members can change their plan at wahealthplanfinder.org.

For Apple Health Classic Medicaid coverage (adults over 65, blind or disabled, and/or needing long-term services and supports), apply online through Washington Connection at washingtonconnection.org or call (877) 501-2233.

HCA will enroll all eligible Members with the health plan of their choice. If the Member does not choose a plan, HCA will assign the Member and his/her family to a plan that services the area where the Member resides. The following groups of Members, eligible for medical assistance, must enroll in a managed care plan:

IMC

- Members receiving Medicaid under the Social Security Act (SSA) provisions for coverage of families receiving Apple Health (AH) Family
- Members who are not eligible for cash assistance but remain eligible for Medicaid.
- Members receiving Medicaid under the provisions of the ACA effective January 1, 2014 (Apple Health Medicaid Expansion)
- Children from birth through 18 years of age eligible for Medicaid under expanded pediatric coverage provisions of the SSA (“H” Children)
- Pregnant women eligible for Medicaid under expanded maternity coverage provisions of the SSA (“S” Women)
- Children eligible for the Children’s Health Insurance Program (CHIP)
- Categorically Needy-Blind and Disabled children and adults who are not eligible for Medicare.
- Members who are eligible for Breast and Cervical Cancer Treatment, Categorically Needy Program
- Members who are eligible for the Categorically Needy Program, Long-Term Care

BHSO

- Dual eligible (Medicare-Medicaid)
- Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support, and Alumni programs
- Members who are eligible for the Medically Needy (spend-down) program
- Non-citizen pregnant women who are not eligible for AHE
- Members who are eligible for Institution for Mental Disease (IMD) and other Medicaid-eligible long-term or residential care

Apple Health Expansion

- Are a Washington resident aged 19 or older and:
  - Have countable income under 138% of the federal poverty level,
  - Do not qualify for other Apple Health programs based on immigration status,
  - Are not pregnant or did not have a pregnancy end in the last 12 months, and
  - Are not eligible for qualified health plans with Advance Premium Tax Credits (APTC) and federally funded medical assistance programs.

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

Effective Date of Enrollment

Earlier enrollment allows Members to be enrolled into a plan the same month they become eligible for Medicaid or AHE, as opposed to waiting until the next month to be enrolled. Earlier enrollment applies to Members who are new to Medicaid or AHE, or who have had a break in eligibility and are recertified for Medicaid or AHE services. The Member is retro-effective to the first of the month they were determined eligible for Medicaid or AHE. The current month's enrollment is intended to allow the Member continuous coverage in managed care from the date of eligibility. When a Member changes health plans, the change will always be effective the first of the following month.

HCA notifies eligible Members of their rights and responsibilities and sends them a booklet at the time of initial eligibility determination. HCA also sends Molina a daily list of assigned Members. Molina sends each new Member a Molina Member ID card and welcome kit within 15 days of initial enrollment. The letter includes important information for the new Members, such as how to access their online handbook and how to contact Molina.

Newborn Enrollment

This information on Newborn enrollment is only applicable to the Medicaid population.

Regardless of what Medicaid program or health plan the Member is enrolled in at discharge (Medicaid Fee-for-Service (FFS) or a managed care plan), the program or plan the Member is enrolled with on the date of admission is responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the Member is discharged to home or a community residential setting.

For newborns born while their mother is hospitalized, the party responsible for the payment of covered services for the mother's hospitalization is responsible for payment of all the newborn's covered inpatient facility and professional services from the date of birth until the date the newborn is discharged from an acute care hospital unless their mother is on FFS Medicaid and the newborn is determined eligible with managed care in the month of birth. If the newborn is not enrolled in managed care in the month of birth, facility costs and professional services will be paid by FFS. A newborn whose mother is receiving services when the baby is born will be enrolled in an Apple Health plan according to Earlier Enrollment rules.

If their mother is not covered during the birth and the newborn is found eligible and enrolled in managed care in the month of birth, the managed care plan will be responsible for all covered inpatient facilities and professional services provided to the enrolled newborn starting from the date of birth or admission. When a newborn is placed in foster care, the newborn will remain enrolled with the Apple Health plan through the month of birth. The newborn will be enrolled with the Apple Health Foster Care (AHFC) program (provided through Coordinated Care) effective the first of the month following placement of the newborn.

Enrollment Exemption: In some cases, a Member may request exemption from enrollment in a plan. Each request for exemption is reviewed by HCA pursuant to Washington Administration Code (WAC) 182-538-130.

Eligibility Verification

Medicaid and Apple Health Expansion Programs

Eligibility is determined on a monthly. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

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

- Molina Member ID card
- Monthly PCP eligibility listing located on Availity Essentials portal
- Molina Member Services at (800) 869-7165

- ProviderOne website

Providers may also use a Medical Eligibility Verification (MEV) service. Molina sends eligibility information, including PCP assignment, to Provider Advantage and Change Healthcare. Some MEV services provide access to online Medicaid Member eligibility data and can be purchased through approved HCA vendors. MEV services provide eligibility information for billing purposes, such as:

- Eligibility status
- Plan enrollment and plan name
- Medicare enrollment
- Availability of other insurance*
- Program restriction information

*Providers should use the Availity Essentials portal and not ProviderOne to verify the availability of other insurance, as there is a window of time during which this information may not be reflected in ProviderOne.

HCA updates the MEV vendor list as new vendors develop MEV services. For more information and a current list of HCA vendors, visit HCA's website at General Verification | Washington State Health Care Authority.

Providers can also access eligibility information for Members free of charge using the HCA's ProviderOne online service. To access eligibility on the website you must register online and complete an application. Online enrollment information can be found at hca.wa.gov/billersproviders/apple-health-medicaid-providers/enroll-provider.

Eligibility Listing for Medicaid Programs

You can verify a Member's PCP assignment by looking up the individual member in the Availity Essentials portal via the Eligibility & Benefits screen. You may also call Molina's Member Services department at (800) 869-7165 to verify eligibility.

PCP Capitation Groups

The table below shows all contracted PCP-capitated groups. These groups receive a per member per month capitation payment to manage all primary care services only for their assigned Medicaid membership. When seeing a new member verify if the member is assigned to a PCP capitated group by looking at their ID card or verifying eligibility on the web portal. If the member is assigned to a PCP-capitated group, the member must be seen by their assigned PCP, or a PCP change needs to be made to the appropriate PCP prior to services being rendered.

PCP Capitation Groups
Community Health Associates Spokane
Cowlitz Family Health
Family Care Network
Family Health Centers
Hudson Bay Medical Group
Kaiser NW
Moses Lake Community Health Center
Pierce Unicare IPA
Rose Medical Group

Identification Cards

An individual determined to be eligible for medical assistance is issued a ProviderOne Services Card by HCA. It is issued once upon enrollment. Providers must use the ProviderOne Client ID on the card to verify eligibility either through the ProviderOne website at waproviderone.org/, or via a Services Card swipe card reader. Providers must check Member eligibility at each visit and should make note of the following information:

- Eligibility dates (be sure to check for the current month and year)
- The ProviderOne Client ID number
- Other specific information (e.g., Medicare, IMC, BHSO, AHE, etc.)

Medical assistance program coverage is not transferable. If you suspect a Member has presented a ProviderOne (Services Card) belonging to someone else, you should request to see a photo ID or another form of identification. To report suspected Member fraud, call the HCA Medicaid Fraud Hotline at (360) 725-0934 or email WAHEligibilityFraud@hca.wa.gov. Do not accept a Services Card that appears to have been altered.

All Members enrolled with Molina receive an ID card from Molina in addition to the Services Card. Molina sends an identification card for each family Member covered under the plan. The Molina ID card has the name and phone number of the Member's assigned PCP.

Members are reminded to carry both ID cards (Molina ID card and Services Card) with them when requesting medical or pharmacy services. Prior to rendering services, it is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment. Unless an emergency condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

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

Disenrollment

Voluntary Disenrollment

Medicaid (IMC, BHSO, and AHE) Members may request a different health plan via wahealthplanfinder.org at any time. IMC and BHSO Members may call or submit a written request to HCA to disenroll from managed care completely and enroll in Fee-For-Service Apple Health (this is not allowed for AHE Members). HCA notifies Molina of all terminations. Neither the Provider nor Molina may request voluntary disenrollment on behalf of a Member.

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

Disenrollment

When a Member becomes ineligible for enrollment due to a change in eligibility status or if the Member has comparable coverage, HCA will disenroll the Member and notify Molina.

A Member whose enrollment with Molina is terminated at any time during the month is entitled to receive covered services at Molina's expense through the end of that month. If the Member is an inpatient at an acute care hospital at the time of disenrollment and the Member was enrolled with Molina on the date of admission, Molina and its contracted medical groups/IPAs shall be responsible for all inpatient facility and professional services from the date of admission through the date of discharge from the hospital unless eligibility to receive Medicaid or AHE services ends.

This includes behavioral health residential treatment facilities or a lower level of care, eligibility to receive Medicaid or AHE services ends, or the Member no longer meets rehabilitative or skilled criteria applicable to the skilled nursing facility setting.

Supplemental Security Income (SSI)

The following section on SSI is only applicable to the Medicaid population; this is not applicable to the Apple Health Expansion (AHE) population.

SSI is a federal income supplement program funded by general tax revenues. It is designed to help aged, blind, and disabled people who have little or no income and provides cash to meet basic needs for food, clothing, and shelter. Members who are eligible for SSI receive medical care through Medicaid FFS and Apple Health Blind Disabled (AHBD) (only non-dual blind and disabled Members) but are not eligible for Apple Health Family (AHFAM), Apple Health with Premium (AHPREM) or Apple Health Adult (AHA).

When identified by case managers, Molina assists Members in pursuing SSI approvals. Until SSI is approved for the Member, Molina, and its contracted medical groups/IPAs are financially responsible for all costs associated with the member's medical management.

AHFAM, AHPREM, and AHA adults who are determined to be SSI eligible due to being blind or disabled will prospectively change eligibility categories to AHBD (blind disabled) and will continue coverage through their designated health plan. Adults determined to be SSI eligible due to being aged will be disenrolled prospectively, and HCA will not recoup any premiums from Molina. Molina and its contracted medical groups/IPAs will be responsible for providing services until the effective date of disenrollment.

If terminated, disenrollment processed on or before the HCA cut-off date will occur on the first day of the month following the month in which the termination is processed by HCA. If the termination is processed after the HCA cut-off date, disenrollment will occur on the first day of the second month following the month in which the termination is processed by HCA.

Molina engages with vendors Centauri Health Solutions and Pacific Disability Resources (PDR), which reach out to Members identified as potentially SSI-eligible individuals. The vendors assist the Member with completing the paperwork needed and tracking the progress of the SSI application.

Maternity and Newborn Coverage

Obstetrical (OB) care is covered for all IMC Members. An IMC newborn is automatically covered through the end of the month in which the 21st day of life falls. Continued coverage is contingent upon the mother reporting the newborn through the wahealthplanfinder.org portal or by calling (855) 923-4633. If eligible, the newborn will receive a Services Card. If the baby is not reported, medical coverage ends at the end of the month in which the 21st day of life falls, unless the baby is in the hospital in which case coverage ends at discharge. If the mother changes health plans within the initial three (3) months of life, the newborn's coverage will follow the mother's coverage.

PCP Assignment

Molina Members have the right to choose their own PCP. If they do not choose a PCP, Molina assigns one to them based on reasonable proximity to their home and prior assignments.

Molina American Indian/Alaska Native (AI/AN) members may request an Indian Health Care Provider (IHCP) who is not contracted with Molina as their PCP by requesting an assignment.

Molina will pay for services provided to a Member by any PCP that participates with Molina or one of the capitated medical groups/IPAs, regardless of whether the Member is currently assigned to that PCP.

If a Member would like to know about a PCP's medical training, board certification, or other qualifications, they can call Member Services. This includes PCPs, specialists, hospitals, and other Providers.

PCP Change

A Member can change their PCP at any time with the change being effective no later than the beginning of the month following the Member's request for the change. If the Member is receiving inpatient hospital services at the time of the request, the change will be effective the first of the month following discharge from the hospital. The guidelines are as follows:

1. If a Member calls to make a PCP change prior to the 15th of the month, the Member will be allowed to retroactively change their PCP to be effective the first of the current month, provided the Member is new to Molina that month.
2. If a Member calls to change the PCP and has been with Molina for over 15 days, the PCP change will be made prospectively to the first of the next month.
3. If the Member was assigned to the incorrect PCP due to Molina's error, the Member can retroactively change the PCP, effective the first of the current month.

Newborn PCP Assignment

- Newborns will be assigned to the mother's PCP through the first full month of coverage following discharge from the hospital.
- The mother may select a different PCP for her newborn effective the first full calendar month after discharge from the hospital by notifying Member Services.
- While assigned to the mother's PCP, the newborn may see the chosen PCP if the PCP is participating with Molina or one of the capitated medical groups/IPAs.
- Molina and its capitated medical groups/IPAs will be responsible for paying for the PCP services provided during this period.
- Newborns enrolled in a Molina plan may receive services from any Molina contracted PCP during the first 60 days after birth.

Financial Responsibility and Medical Management Authority

If the mother's PCP is part of a contracted medical group/IPA, that group/IPA will be financially responsible for covered services and has the authority to medically manage the newborn until the end of the first full calendar month of coverage after discharge from the hospital. If a hospitalized newborn loses eligibility, the contracted medical group/IPA or Molina is responsible for coverage until the newborn is discharged from the acute care facility. A transfer from one acute care facility to another is not considered a discharge.

PCP Dismissal

A PCP may dismiss a Member from his/her practice based on the following reasons. The issues must be documented by the PCP:

- Repeated "No-Shows" for scheduled appointments.
- Inappropriate behavior
- PCP is unable to provide the services needed by the member because the care is outside the PCP's scope of practice.
- Member no longer meets the age requirements of the practice.

This Section does not apply if the Member's behavior is resulting from their special needs, except when their continued assignment to the PCP seriously impairs the PCP's ability to furnish services to either the individual Member or other Members. The Member must receive written notification from the PCP explaining in detail the reasons for dismissal from the practice. The Provider may use the approved "Dismissal Letter" located on the Molina website at MolinaHealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/wa/Medicaid/forms/Dismissal-Letter.pdf.

The PCP may use their own dismissal letter after approval by Molina. A copy of the dismissal letter should be faxed to Member Services at (800) 816-3778. Molina will contact the Member and assist in selecting a new PCP. The current PCP may refer the Member to the ER for emergency care during the 30-day transition period.

If a PCP wants to dismiss a member for any other reason, please contact your Provider Relations representative.

PCP Panel Closure – "New Members"

If a PCP determines that they are unable to accommodate "new" Members they can elect to close their panel. Molina must receive 30 days advance notice from the Provider. Once the panel is closed, no new Members will be assigned to the PCP with the following exceptions:

- Family Members of existing Members will continue to be assigned.
- Members who were previously assigned to the PCP prior to a loss of eligibility will continue to be "reconnected" to the PCP.

- Members for whom a PCP has provided services two (2) or more times in a 12-month period. The system automatically reassigns the Member based on claims data.

To request the change in panel status (closed or open), the provider must fill out the Provider Change Form and email it to MHWProviderInfo@MolinaHealthcare.com. The form must include the reason and the effective date of the status change.

PCP Panel Closure – "New & Previously Assigned Members"

In the event a PCP determines they are unable to serve not only New Members but also Members who have been previously assigned, the PCP must close his or her panel by immediately completing the Provider Change Form and emailing it to MHWProviderInfo@MolinaHealthcare.com.

Molina will identify those Members for potential re-assignment to another PCP using the following objective criteria:

- Members were assigned to the PCP within the last one (1)-six (6) months.
- Member has never been seen by the PCP and does not have a scheduled appointment.
- Member is not a family member of a Member being actively seen by the PCP

The current PCP must provide emergency care to the Member for 30 days during this transition period.

6. BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and Covered Services for Molina Washington Apple Health Integrated Managed Care (IMC) Members including:

- Apple Health IMC with Premium (IMC-PREM)
- IMC Family/Pregnancy Medical (IMC-AH)
- IMC Adult (IMC-AHA)
- IMC Aged, Blind, Disabled (IMC-AHBD)
- Behavioral Health Services Only (BHSO)
- Apple Health Expansion (AHE)

Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization. Please reference the Prior Authorization tools located at on the Molina website and the Availity Essentials portal. You may also please contact Molina at (855) 322-4082, Monday through Friday, 7:30 a.m. to 6:30 p.m.

In addition to receiving health care services from providers who contract with Molina, Members may self-refer and receive certain benefits through local health departments, school-based health centers, family planning clinics, or Indian Health Care Providers (IHCP) for the following:

- Family planning services and supplies
- Immunizations
- Tuberculosis (TB) screening and follow-up care
- Sexually Transmitted Disease (STD) screening and treatment services
- HIV or AIDS testing
- Behavioral health services
  - Assessment and intake
- Women's health services
- Crisis response services
  - Crisis intervention
  - Crisis respite
  - Investigation and detention services
  - Evaluation and treatment services

Washington Apple Health

Washington Apple Health is the name used in Washington State for Medicaid, the Children's Health Insurance Program (CHIP) and state-only funded health care programs include Integrated Managed Care (IMC) and Behavioral Health Services Only (BHSO). HCA contracts with several health plans to provide health care to eligible client groups. It is a prepaid, comprehensive

system of medical and behavioral health care delivery that includes preventive, primary, specialty, and ancillary health services.

IMC includes Clients eligible for:

- Temporary Assistance for Needy Families (TANF)
- Pregnant women with family incomes up to 193% of the Federal Poverty Level (FPL)
- Children with family incomes up to 312% of FPL not eligible for other Medicaid programs
- Blind and Disabled (SSI) children and adults not eligible for Medicare.
- Adult Medical or Medicaid Expansion up to 133% of FPL
- Breast and Cervical Cancer Treatment, Categorically Needy Program
- Categorically Needy Program, Long Term Care

Clients receive their health benefits by accessing care through providers who contract with a health plan.

Service Covered by Molina

Molina covers the services described in the Benefit Index. If you have questions about whether a service is covered or requires prior authorization, please reference the Prior Authorization tools on the Molina website and the Availity Essentials portal. You may also contact Molina at (855) 322-4082, Monday through Friday, 7:30 a.m. to 6:30 p.m.

Molina provides a Behavioral Health benefit for Members. It takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health providers, and other specialty Providers to ensure whole-person care. Unless otherwise noted in this section, all provisions within the Provider Manual apply to medical and behavioral health Providers.

BHSO is for specialty behavioral health (mental health and substance use disorder) services only. BHSO Members receive their physical health care and all medication through their primary medical coverage, such as Medicare (traditional or Part C), private health insurance, or Medicaid fee-for-service. They must meet spend-down requirements before they are eligible for Apple Health benefits.

Under the BHSO line of business, providers can bill MHW for high-acuity behavioral health services and bill ProviderOne for low-acuity behavioral health services, which fall under the member's physical health benefits package.

Link(s) to Benefit Information

The following web link provides access to the benefit information for the Benefit Index Apple Health IMC and BHSO offered by Molina in Washington state.

For more information on how to identify the correct payer for low-acuity and high-acuity services, go to hca.wa.gov/assets/billers-and-providers/providers-identify-payer-table.pdf. The Health Care Authority Mental Health Services Billing Guide can be found at the following website: Provider billing guides and fee schedules | Washington State Health Care Authority.

Washington Apple Health Expansion

Washington Apple Health Expansion (AHE) is the name used in Washington State for a health coverage program that covers individuals 19 and older who are otherwise disqualified from receiving benefits through the traditional Apple Health program. It is a prepaid, comprehensive system of medical and behavioral health care delivery that includes preventive, primary, specialty, and ancillary health services. HCA contracts with several health plans to provide health care to eligible Client groups.

The AHE population includes Clients eligible for:

- Are a Washington resident aged 19 or older and:
- Have countable income under 138% of the federal poverty level,
- Do not qualify for other Apple Health programs based on immigration status,
- Are not pregnant or did not have a pregnancy end in the last 12 months, and
- Are not eligible for qualified health plans with Advance Premium Tax Credits (APTC), federally
  funded medical assistance programs
- Clients receive their health benefits by accessing care through providers who contract with a health plan.

Service Covered by Molina

Molina covers the services described in the Apple Health Expansion Benefit Index. If there are questions as to whether a service is covered or requires prior authorization, please reference the Prior Authorization tools located on the Molina website and the Availity Essentials portal. You may also contact Molina at (855) 322-4082, Monday through Friday, 7:30 a.m. to 6:30 p.m.

Molina provides a Behavioral Health benefit for Members. It takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health providers, and other specialty Providers to ensure whole-person care. Unless otherwise noted in this section, all provisions within the Provider Manual apply to medical and behavioral health Providers.

Key Benefit Differences: Washington Apple Health (Medicaid) and Apple Health Expansion

Washington Apple Health (Medicaid) and Apple Health Expansion (AHE) members are generally entitled to the same physical and behavioral health benefits; however, there are a few notable differences in coverage between the Medicaid and Apple Health Expansion populations.

Apple Health Expansion members are **not eligible** for the following benefits and programs: EPSDT-like requirements and EPSDT-like benefits for services covered by other state agencies.

- Benefits operated by other state agencies as Medicaid State Plan services (not allocated in other state agency budgets) including:
  - Intermediate Care Facilities/ICF (DSHS)
  - Private Duty Nursing for Adults, including 19-20y* (DSHS/DDA)
  - Behavioral Rehabilitative Services/BRS (DCYF)
  - Medicaid Personal Care/MPC (DSHS)
  - Community First Choice (1915k SPA authority) (DSHS)
  - HIV case management (DOH)
- Intensive Behavioral Supportive Supervision (IBSS)
- Health Homes
- Medicaid Waiver Services (Waiver authority does not include population), including:
  - Medicaid Transformation services (e.g., Re-entry & HRSN services)
  - 1915c Home and Community-Based Services (HCBS)
  - 1915b for Behavioral Health Services Only (BHSO) program
  - 1915i for Supportive Supervision and Skills Restoration

Obtaining Access to Certain Covered Services

Non-Preferred Drug Exception Request Process

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

- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within 24 hours of receiving the complete request.
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within 24 hours of receiving the complete request.
- Members will also have the right to appeal a denial decision, per any requirements set forth by the state of Washington.

Molina will allow a 72-hour emergency supply of prescribed medication for dispensing when prior authorization is not available. Pharmacists will use their professional judgment regarding whether there is an immediate need every time the 72-hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

Specialty Drug Services

Many 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.

Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes, and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations representative with any further questions about the program.

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. For additional information about our prior authorization process, including a link to the Prior Authorization request form, please refer to the **Pharmacy** section of this Provider Manual.

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

Access to Behavioral Health Services

Behavioral health services are a direct access benefit and are available with no referral required. Healthcare professionals may assist Members in finding a Behavioral Health Provider, or Members may contact Molina's Member Support Center at (800) 869-7165. Molina's Nurse Advice Line is available 24 hours a day, 7 days a week, 365 days per year for mental health or substance abuse needs. The services Members receive will be confidential.

The benefit information linked above provides additional detail regarding covered services and any limitations which can be obtained by contacting Molina. If inpatient services are needed, prior authorization must be obtained unless the admission is due to an emergency, and inpatient Member cost share will apply.

Emergency Mental Health or Substance Use Disorders services

Members are directed to call 988, 911 or go to the nearest emergency room if they need Emergency mental health or substance abuse. 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 health emergency who cannot get to a Molina approved Provider are directed to do the following:

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

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

Please note that the Medicaid and AHE programs do not provide coverage outside of the United States.

Washington Recovery Help Line

The Washington Recovery Help Line is the consolidated helpline for substance use, problem gambling, and mental health, as authorized and funded by The Washington State Department of Social and Health Services' Division of Behavioral Health and Recovery. It is a 24-hour crisis intervention and referral line for those struggling with issues related to mental health, substance use, and problem gambling. Professionally trained volunteers and staff provide confidential support and referrals to detox, treatment, and recovery support groups. WA state residents can access services 24 hours a day at (866) 789-1511 or warecoveryhelpline.org.

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 transport. See Ambulance Transportation Billing Guide (wa.gov) for more information.

Non-Emergency Medical Transportation

For Molina Apple Health Members to have non-emergency medical transportation (NEMT) as a Covered Service, the Health Care Authority (HCA) covers transportation to medical facilities when the Member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, etc.). Examples of non-emergency medical transportation include but are not limited to, litter vans and wheelchair-accessible vans. If you want to arrange transportation for a Member to travel to/from their healthcare service provider, contact the regional transportation broker for the Member's county of residence. Refer to hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaidcoverage/transportation-services-non-emergency.

Preventive Care

Preventive Care Guidelines are located at MolinaHealthcare.com, in the Health Resources section within our provider web pages. Please use the link below to access the most current guidelines https://www.molinahealthcare.com/members/wa/en-us/mem/medicaid/imc/covered/hm/education-programs.aspx. We need your help conducting these regular exams to meet the targeted state and federal standards. If you have questions or suggestions related to well-childcare, please call our Health Education line at (866) 472-9483 (TTY/TDD: 711).

Immunizations

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

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

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

Well-Child Visits and EPSDT Guidelines

The following section on Well-Child Visits and EPSDT is applicable to the Medicaid population only. The Apple Health Expansion population is not covered under EPSDT.

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

follow the recommendations from the AAP and Bright Futures. Additional information on EPSDT benefits covered by Washington State Health Care Authority (HCA) is available at MolinaHealthcare.com/providers/wa/medicaid/resource/guide_prevent.aspx. The screening services include:

- Comprehensive health and developmental history (including assessment of both physical and mental health development).
- Immunizations in accordance with the most current Washington state Recommended Childhood Immunization Schedule, as appropriate. Or CDC Advisory Committee on Immunization Practices (ACIP) childhood immunization schedule as appropriate
- Comprehensive unclothed physical exam
- Comprehensive unclothed physical exam.
- Laboratory tests as specified by the AAP, including screening for lead poisoning*.
- Health education.
- Vision services.
- Hearing services.
- Dental services.

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

We need your help conducting these regular exams to meet the Health Care Authority Targeted State standard. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well childcare, please call our Health Education line at (866) 891-2320.

*Protecting children from exposure to lead is important to lifelong good health. No safe blood lead level in children has been identified. Even low levels of lead in blood have been shown to affect learning, ability to pay attention, and academic achievement.

Vaccines for Children

Since 1990, the Washington State Immunization Program has been providing vaccines to all children under the age of 19, regardless of their income level, through a combination of state and federal funds. In 1994, the federal government provided an additional funding source through the Vaccines for Children (VFC) program. The Centers for Disease Control and Prevention (CDC), which provides VFC funding, has developed strict accountability requirements from the state, local health jurisdictions, and individual providers. The Vaccines for Children (VFC) Program helps provide vaccines to ensure that all children have a better chance of getting their recommended vaccinations on schedule. Vaccines available through the

VFC Program are those recommended by the Advisory Committee on Immunization Practices (ACIP).

Molina Providers are encouraged to enroll in the VFC program through their local health department.

State-supplied vaccines are provided at no cost to enrolled providers through the local health department. Washington is a "universal vaccine distribution" state. This means patients cannot be charged fees for the vaccines themselves, and no child should be denied state-supplied vaccines for inability to pay an administration fee or office visit.

Molina follows HCA Medicaid Provider Guides for reimbursing a provider's administration costs. Providers must bill state-supplied vaccines with the appropriate procedure codes and an SL Modifier for identification and reporting purposes. More specific information regarding billing for state-supplied vaccines can be found on the Physician Related Services/Health Care Professional Services Provider Guide at hca.wa.gov/billers-providers-partners/priorauthorization-claims-and-billing/provider-billing-guides-and-fee-schedules.

For more information on the VFC program, visit Childhood Vaccine Program | Washington State Department of Health

Prenatal Care

Stage of Pregnancy	How often to see the doctor
1 month – 6 months	1 visit a month
7 months – 8 months	2 visits a month
9 months	1 visit a week
Postpartum	7 to 84 days after delivery
Note: More visits may be needed if recommended by the Provider or if pregnancy is at high risk for complications.	

Emergency Services

Emergency Services means: Inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition.

Molina covers emergency and urgent care Services without authorization. This includes non-contracted Providers inside or outside Molina's service area.

24-hour Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week, 365 days a year.

Molina is committed to helping our Members:

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

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

Virtual Urgent Care

To enable members to access care after hours and when lack of transportation or childcare resources inhibits their ability to see their provider, Molina offers Virtual Urgent Care 24/7. Learn more at: https://www.molinahealthcare.com/members/wa/en-us/hp/medicaid/imc/covered/virtual-care.aspx

Health Management Programs

Molina offers programs to help our Members and their families manage various health conditions.

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

Telehealth and Telemedicine Services

Molina Members may obtain physical and behavioral health Covered Services by Participating Providers, using 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.
- Members have the option of receiving PCP services through telehealth. If they choose this option, they must use a Network Provider who offers telehealth.
- 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 must be coded in accordance with applicable reimbursement policies and billing guidelines.
- Rendering Providers must comply with applicable federal and state guidelines for telehealth service delivery.

For additional information on Telehealth and Telemedicine Claims and billing please refer to the **Claims and Compensation** section of this Provider Manual.

7. HEALTH CARE SERVICES

Introduction

Health Care Services comprises Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based on empirically validated best practices that have shown positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides CM 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 UM program include pre-service authorization review, inpatient authorization management that includes admission and concurrent medical necessity review, and restrictions on the use of out-of-network or non-participating 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 offered across a continuum of care and integrates a range of services appropriate to meet individual needs. Molina's UM program maintains flexibility to adapt to changes in the Member's condition and is designed to influence a 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.
- Review processes to ensure care is safe and accessible.
- Ensuring qualified health care professionals perform all components of the UM processes.
- Ensuring UM decision-making tools are appropriately applied in determining medical necessity decisions.

Key Functions of the UM Program

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

- **Eligibility and Oversight**
  - Eligibility verification
  - Benefit administration and interpretation
  - Verification that authorized care correlates to Member's medical necessity need(s) and benefit plan
  - Verifying of current Physician/hospital contract status

- **Resource Management**
  - Prior Authorization and referral management
  - Admission and Inpatient Review
  - Referrals for Discharge Planning and Care Transitions
  - Staff education on consistent application of UM functions

- **Quality Management**
  - Evaluate satisfaction of the UM program using Member and Provider Input
  - Utilization data analysis
  - Monitor for possible over- or under-utilization of clinical resources.
  - 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/IPAs and delegated entities that assume responsibility for UM must adhere to Molina's UM Policies. Molina reviews their programs, policies, and supporting documentation at least annually.

UM Decisions

An organizational determination is any decision made by Molina or the delegated medical group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination)
- Determination to delay, modify, or deny authorization or payment of request (adverse determination)

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 reviewers from appropriate specialty areas are used to help determine medical necessity, as appropriate. All utilization determinations are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with federal and state regulatory requirements and NCQA standards.

Requests for authorization not meeting medical necessity 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 authorization of services to a Member. Molina's use and interpretation of the American Society of Addiction Medicine's ASAM Criteria for Addictive, Substance-Related, and Co-Occurring Conditions does not imply that the American Society of Addiction Medicine has either participated in or concurs with the disposition of a claim for benefits.

Providers can contact Molina's Healthcare Services department at (855) 322-4082 to obtain Molina's UM Criteria.

Where applicable, Molina clinical 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.

Medical Necessity

"**Medically Necessary**" or "**Medical Necessity**" means requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the Enrollee that endanger life, cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap or cause physical deformity or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the Enrollee requesting the service. To this Contract, the "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).

This is for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms. Those services must be deemed by Molina to be:

In accordance with generally accepted standards of medical practice.

1. Clinically appropriate and clinically significant in terms of type, frequency, extent, site, and duration. They are considered effective for the patient's illness, injury, or disease; and,
2. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services

and 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, by itself, make such care, goods, or services medically necessary, a medical necessity, or a covered service/benefit.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Molina has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity Essentials portal. With MCG Cite for Guideline Transparency, Molina can share clinical indications with Providers. The tool operates as a secure extension of Molina's existing MCG investment and helps meet regulations around transparency for the 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 Guideline Transparency does not affect the process for notifying Molina of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

Molina has also partnered with MCG Health, to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging prior authorization (PA) requests.

Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24 hours per day, 7 days per week. This method of submission is the primary submission route for advanced imaging requests. Molina will also be rolling out additional services throughout the year. Clinical information submitted with the PA will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each PA request and sending it directly to Molina, health care providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical

information and attached guideline content to the procedure to determine the potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs, PET scans. To see the full list of imaging codes that require PA, refer to the PA code Look-up Tool at Washington Providers Home (molinahealthcare.com)

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, Molina clinical policies, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

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

All UM requests that may lead to a medical necessity adverse determination are reviewed by a Molina health care professional (medical director, pharmacy director, or appropriately licensed health care professional).

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

Clinical Information

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

Prior Authorization

Molina requires prior authorization for specified services if it complies with federal or state regulations and the Provider Services Agreement with Molina. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and

HCPCS codes. Molina prior authorization documents are customarily updated quarterly but may be updated more frequently as appropriate, and are posted on the Molina website at Washington Providers Home (molinahealthcare.com)

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

- Member demographic information (name, date of birth, Molina Member ID number).
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested service is required including:
    - Pertinent medical history (including treatment, diagnostic tests, and 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 follows all prior authorization requirements related to care for newborns and their mothers in alignment with the Newborns' and Mothers' Health Protection Act (NMHPA).

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

Molina will make an organizational decision as promptly as the Member's health requires and no later than contractual and regulatory requirements. Expedited timeframes are followed when the Provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health.

Providers who request prior authorization for services and/or procedures may request to review the criteria used to make the final decision. A Molina Medical Director is available to discuss medical necessity decisions with the requested Provider at (855) 322-4082 during business hours.

Upon approval, the requester will receive an authorization number. The number may be provided by telephone, fax, or via the Availity Essentials portal. If a request is denied, the requester and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Providers may receive notifications or denials via fax or the Availity Essential portal.

Evolent (formerly known as New Century Health)

Molina collaborates with Evolent to conduct a medical necessity review on certain prior authorizations (PA) requests. PA requests for Participating Servicing Providers are to be submitted to Evolent for professional services review and decisions for Molina Members ages 21 and over to Evolent. All out-of-network Servicing Provider PA requests and PA requests for Molina Members under the age of 21 will be reviewed by Molina.

Evolent conducts reviews for the following related professional services:

Cardiology

- Non-Invasive Cardiology
- Non-Invasive Vascular
- Cardiac Cath and Interventional Cardiology
- Vascular Radiology and Intervention
- Vascular Surgery
- Thoracic Surgery
- Cardiac Surgery
- Electrophysiology

Please consult the PA Lookup Tool for further guidance on where to submit professional services PA requests.

Please consult the PA Lookup Tool for further guidance on where to submit professional services PA requests. Providers are to follow Molina's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity, and a decision will be made at that time. If other services are performed during the inpatient stay that are unrelated to the cardiac procedures, a separate authorization will need to be completed through Molina's standard prior authorization process for medical necessity determination.

Medical Oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0

Infused, injectable and oral* chemotherapy, hormonal therapeutic treatment, supportive agents, and symptom management medications.

**Pharmacy benefit single oral agent requests are out of scope for Evolent and pre-authorization must be obtained from Molina or applicable Pharmacy Benefits Manager (PBM). For Marketplace Members, Pharmacy benefits oral agents submitted in a request combined with infused/injectable cancer agents will be reviewed by Evolent for preauthorization.*

Radiation Oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0

- Brachytherapy
- Conformal
- IMRT (Intensity-modulated radiation therapy)
- SBRT (Stereotactic Body Radiation Therapy)
- IGRT (Image-guided radiation therapy)
- 2D, 3D (2 or 3 dimensional)
- SRS (Stereotactic radiosurgery)
- Radiopharmaceuticals
    - Proton and Neutron Beam Therapy

CAR-T

For inpatient CAR-T service requests, the inpatient status will be approved when medical necessity criteria are met, simultaneously with the approval of the CAR-T professional service(s) being reviewed.

T Providers are to follow Molina's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time. If other services are being performed during the inpatient stay that are unrelated to the CAR-T procedures, a separate authorization will need to be completed through Molina's standard prior authorization process for medical necessity determination.

PA request submission

The requesting in-network Provider must complete a prior authorization request using one of the following methods:

- For Providers' convenience, logging into the Evolent Provider Web Portal is the preferred submission method: my.newcenturyhealth.com
- Evolent's Provider Web Portal functionality offers instant approvals or denials for prior authorization requests
- Calling (888) 999-7713:
    - Cardiology – Option 1
    - Medical Oncology – Option 2

- Radiation Oncology – Option 3

Providers that cannot use the provider portal may submit prior authorization requests and supporting clinical documentation using the eFax or email addresses below.

Specialty	eFax #	eFax Email Address
Cardiology	(877) 370-0963	efax-carepro-mol-cardio@evolent.com
Radiation Oncology	(877) 380-7848	efax-carepro-mol-radonc@evolent.com
Medical Oncology	(877) 230-4493	efax-carepro-mol-medonc@evolent.com

Providers should call the Evolent Network Operations department at (888) 999-7713, Option 6, with questions or for assistance with access/training on the Evolent Provider Web Portal. You may also email your questions to providertraining@newcenturyhealth.com.

Evolent: Retro-authorization

Molina allows a 14-day retro period from the date of service to request additional services that may not have been in the initial request. Due to Evolent not reviewing retro services, if you need to add additional services within 14 days of the date of service, please submit a retro request via fax to Molina at (800) 767-7188.

Evolent: peer-to-peer review

Peer-to-peer review will be conducted by Evolent via physician discussions with expanded collaboration to better discuss treatment plans.

Providers are strongly encouraged to take advantage of Evolent's streamlined peer-to-peer process to hold timely conversations related to requested services.

Peer-to-Peer Review

In the case of an adverse determination, the requesting provider has the option to submit a reconsideration request or schedule a Peer-to-Peer discussion with a medical director within the time frames listed below to avoid the appeals process. Pursuing these options is appropriate when additional information or context not provided in the clinical information may result in approval.

For the Peer-to-Peer discussion, a "peer" is considered the Member's or Provider's clinical representative (licensed medical professional). Contracted external parties, administrators, or facility UM staff can only request that a peer-to-peer telephone communication be arranged and performed but the discussion should be performed by a peer.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and ID#
- Auth ID#
- Requesting Provider Name and contact number and best times to call

Peer-to-Peer

- May be requested within **five (5) business days** from adverse benefit determination (denial) notification (written or fax notification) or at any time during an inpatient admission.
- May not be requested if a formal appeal has been filed.
- May not be requested when no clinical information was submitted, and the denial was based on lack of information. In this case, please follow the Reconsideration pathway. Submitting clinical information with a Reconsideration request may result in an approval or a revised denial that would come with new Peer-to-Peer and Reconsideration timeframes.
- Time period to request a **Peer-to-Peer: five (5) business days**.

Reconsideration by the Utilization Management Department

- May be requested within **14 calendar days** from adverse benefit determination (denial) notification (written or fax notification);
- May be requested if new clinical information is available that was not previously submitted at the time of the initial denial determination.
- May be requested if no clinical information was submitted and the denial was based on lack of information.
- May be requested following discharge from an inpatient level of care.
- May be requested if the provider is unable to request a Peer-to-Peer discussion within three (3) business days after the adverse benefit determination (denial) notification.
- Reconsideration cannot be requested following a Peer-to-Peer discussion. In this case, please follow the appeal pathway for further dispute rights.
- Time period to request a **Reconsideration: 14 calendar days**.

Scheduling a Peer-to-Peer

Please call (425) 398-2603 to request and schedule a Peer-to-Peer discussion or if you have questions regarding the Peer-to-Peer or Reconsideration process.

Peer-to-peer discussions will be scheduled Monday through Friday from 9 a.m. to 4 p.m. PST, excluding holidays. For Advance Imaging (AI) authorizations, please call (855) 714-2415 (enter 92 for WA). A Molina Medical Director will call you at your scheduled date and time, at the direct number provided.

Requesting Prior Authorization

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

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the Washington Providers Home (MolinaHealthcare.com)website:

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

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

Availity Essentials portal: . Participating Providers are should use the Availity Essentials portal for prior authorization submissions. All prior authorization submissions must include supporting clinical documentation to ensure timely and accurate review. Instructions for how to submit a prior authorization request are available on the Availity Essentials portal. The benefits of submitting your prior authorization request through the Availity Essentials portal are:

- Create and submit Prior Authorization Requests
- Check the status of Authorization Requests
- Receive notification of change in status of Authorization Requests
- Attach medical documentation required for timely medical review and decision-making
- Receive notification of authorization decisions
- Access prior authorization letters directly through the new DC Hub functionality in the Availity Essential portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.

Fax: Please use the Molina PA request form on our website at Washington Medicaid—Frequently Used Forms.

Be sure to send the form to the attention of the Healthcare Services Department and include, along with your request, the supporting documentation needed for Molina to facilitate an expeditious turnaround.

Molina Healthcare:

- Medical/Behavioral Health: (800) 767-7188
- Advanced Imaging: (877) 731-7218
- Transplant: (877) 813-1206
- Kaiser Foundation Health Plan of the Northwest: (877) 800-5456

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services department at (855) 322-4082 or Kaiser Foundation Health Plan of Northwest at (800) 813-2000 for Kaiser patients. 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 advocate for their patients. Molina requires provisions within Provider contracts that prohibit the solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

Molina and its contracted Providers may not enter 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 be able to 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 by calling (855) 322-4082 during normal business hours, Monday through Friday (except for holidays) from 8:00 a.m. a.m. to 5:00 p.m. All staff members identify themselves by providing their first name, job title, and organization.

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

After business hours, Providers can also utilize fax and the Availity Essentials portal for UM access.

Molina's Nurse Advice Line is available to Members 24 hours a day, 7 days a week at (888) 275-8730 (English) and (866) 648-3537 (Spanish). Molina's Nurse Advice Line may handle after-hours UM calls.

Emergency Services

Emergency Services means: a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that Emergency Medical Condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital.

Emergency Medical Condition or Emergency means: a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Emergency care for behavioral health conditions means services provided for an individual that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability.

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

All members experiencing an emergency medical condition are covered by emergency services 24 hours a day without the need for prior authorization.

Post-stabilization care services are covered services that are:

1. Related to an emergency medical condition.
2. Provided after the Member is stabilized; and
3. Provided to maintain the stabilized condition or, under certain circumstances, to improve or resolve the Member's condition.

Inpatient admission requests (not including post-stabilization requests) received via fax or the Availity Essentials portal will be processed within standard inpatient regulatory and contractual time frames.

Molina also provides Members with a 24-hour Nurse Advice Line for medical advice. 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 ambulances and hospitals. An out-of-network emergency hospital stay may only be covered until the Member has stabilized sufficiently to transfer to an available

participating facility. Services provided after stabilization in a non-participating facility may not be covered, and the Member may be responsible for payment.

Members over-utilizing the emergency department will be contacted by Molina care managers to aid 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 they cannot be seen by the PCP.

Inpatient Management

Planned Admissions

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

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission, and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, medical necessity requirements, or failure to include all the needed clinical documentation to support the need for an inpatient admission may result in a denial of authorization for the inpatient stay.

Inpatient at the time of Termination of Coverage

When a Member's coverage with Molina terminates during a hospital stay, Molina will continue to cover services through discharge unless law or program requirements mandate otherwise.

Inpatient/Concurrent Review

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

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

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

Inpatient Status Determinations

Molina's UM staff follow federal and state guidelines along with evidence-based criteria 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 Review subsection of this Provider Manual).

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care as soon as possible after admission.

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

Readmissions

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

Readmission to the same acute facility within 14 days of the initial or index admission will be subject to clinical reviews if the readmission is determined to be related to the previous admission (WAC 182-550-2950).

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:

- Readmission for reasons unrelated to conditions or care from index or initial admission.
- Repetitive treatments such as cancer chemotherapy or other required treatments for cancer, transfusions for chronic anemia, burn therapy, dialysis, or other planned treatments for renal failure.
- Planned therapeutic or procedural admission following diagnostic admissions when the therapeutic treatment clinically could not occur during the same case.
- Same day planned admission to a different hospital unit for continuing care and can include mental health/substance use disorder transfers and rehabilitation transfers, which may be technically coded as discharge/admission for billing reasons.
- Required treatments for cancer, including treatment-related toxicities or care for advanced-stage cancer.
- End of life and hospice care.
- Patients who left Against Medical Advice (AMA) from index or initial admission.
- Readmission due to patient non-adherence to the discharge plan, despite appropriate discharge planning. This also includes cases where the recommended discharge plan was refused by the patient and a less appropriate alternative plan was made to accommodate patient preferences; this must be clearly documented in the record.
- Obstetrical readmission for birth after an antepartum admission.
- Admissions with a primary diagnosis of mental health and substance use disorder issues.
- Transplant readmissions within 180 days of transplantation.
- Neonatal readmissions.
- Readmissions when the index admission occurred in a different hospital system.

Effective January 15, 2022: As Molina performs admission reviews if readmission to the same hospital/same diagnosis within 24 hours after leaving against medical advice is noted, the hospital will be informed that the readmission will be combined with the initial admission and processed as a continued stay. A single payment will be considered full payment for the first and second hospital admissions.

Administrative Days

Hospitals are not required to request administrative days. Enrollees who are eligible for administrative days will automatically be granted them as appropriate when the requirements of WAC 182-550-4550 are met. All hospitals are entitled to bill administrative days, including mental health, LTAC, physical medicine, and rehabilitation. Administrative days are intended for Mental Health services in a community hospital only and not available for service provided in an

evaluation/treatment center. Admin days for BHSO members should be billed to Fee-for-Service.

Administrative days must be billed on a separate Claim form:

- For acute care stay paid under DRG - revenue code 0191 must be billed on the Claim for administrative days, and the acute care stay Claim must be billed with the inpatient status code
- 30 to indicate a separate Claim will be submitted for administrative days
- For per-diem – paid services bill with revenue code 0169
- Providers can refer to the Inpatient Hospital Billing guide for billing specifics.

Newborn Administrative Days

Up to five (5) days of an administrative day may be authorized for inpatient hospital stay for the postpartum parent following the parent's medical discharge when the newborn remains as an inpatient on a hospital Claim at the facility. "Postpartum parent" is defined as the client who carried the pregnancy and has delivered the baby(ies). The newborn administrative day rate is payable if the inpatient hospital days meet all the following criteria:

1. **Newborn:** The newborn was exposed in utero to a substance or substances that may lead to physiologic dependence and continuous care by the postpartum parent is the appropriate first-line treatment (e.g., "Eat, Sleep, Console" or another non-pharmacologic similar model defined by continuous care by the birth parent).
2. **Postpartum parent:** The postpartum parent can room with the newborn and provide continuous support and care. The additional inpatient hospital days on the newborn administrative day rate are for the postpartum parent.
3. **Medication:** The billing provides all prescribed medications to the postpartum parent for the duration of the stay, including medications prescribed to treat substance use disorder. These should be billed as a separate line item from the inpatient pharmacy, per WAC 182-550-4550.
4. **Additional Services:** The billing hospital provides at least the following services to the postpartum parent while inpatient under this newborn administrative day rate: a hospital bed/rooming in with the newborn, nutritional support for the parent, and other services depending on the newborn's needs (e.g., lactation support, nursing assessment and intervention, rounding, discharge planning)

Billing for 5 Allowable Newborn Administrative Days

To receive payment the hospital must bill newborn administrative days with revenue code 0191 with ICD 10 diagnosis code O99.320 (drug use complicating pregnancy) on the postpartum parent's Provider One ID. Pharmaceuticals prescribed for the client's use during the administrative portion of their stay must be billed and will be paid on a Claim separate from that of the acute care stay. For the acute care stay Claim, the Provider must bill with inpatient status code 30 to indicate the Provider will be submitting a separate Claim for newborn

administrative days and include a Claim note that states “Admin. days claim to follow.” Providers can refer to the Inpatient Hospital Billing guide for billing specifics.

Additional Monitoring Days Prior to Discharge

Facilities may request additional newborn administrative days (i.e., beyond day five) if the days meet the newborn, postpartum parent, medication, and additional services criteria specified in the previous section, and the following additional criteria are met:

1. The newborn requires ongoing monitoring and does not meet the criteria for discharge as they are having difficulty with one or more of the following:
    a. Feeding or sucking or poor weight gain.
    b. Gastrointestinal disturbance (e.g., vomiting, diarrhea, cramping);
    c. Sleep (i.e., falling asleep or maintaining sleep); or
    d. Being consoled (e.g., excessive crying or irritability, tremors, hypertonia).
2. The newborn must be able to receive continuous care from a postpartum parent:
    a. Newborn has not transferred into the Neonatal Intensive Care Unit (NICU) or the Pediatric Specialty Unit for closer monitoring.
    b. The postpartum parent is staying at the hospital to provide continuous care.

Post Service Review

Failure to obtain authorization when required may result in denial of payment for those services. The only possible exception for payment because of 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. In those cases, a medical necessity review will be performed. Decisions, in this circumstance, will be based on medical necessity.

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 practitioners and licensed staff unhindered by fiscal or administrative concerns. Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Molina requires that all utilization-related decisions regarding Member coverage and/or services are based solely on the appropriateness of care and the existence of coverage. Molina does not specifically reward Practitioners or other individuals for issuing denials of coverage or care. 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 temporarily outside the service area, without prior authorization or as otherwise required by federal or state laws or regulations.

Avoiding Conflict of Interest

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

Molina does not reward Providers or other individuals for issuing coverage or care denials. Furthermore, Molina never provides financial incentives to encourage authorization decision-makers to make determinations that result in underutilization. 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 the identification of resources available to the Member, such as community programs, national support groups, appropriate specialists and facilities, and identifying best practices or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members, and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

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 the 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 their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition—Following termination, the terminated Provider will continue to provide covered services to the Member for 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 of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer, if necessary, for a safe transfer.

For additional information regarding continuity of care and member transitions, please call Molina at (855) 322-4082.

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

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

- Physicians, dentists, interns, residents, or nurses.
- Public or private school employees or 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

Washington State's toll-free, 24-hour, 7-day-a-week hotline will connect you directly to the appropriate local office to report suspected child abuse or neglect.

Hotline: 866-ENDHARM (866-363-4276)

TTY Callers: (800) 624-6186

Adult Abuse

Office of the Attorney General's Vulnerable Adult Abuse reporting line at (866) 363-4276 (866END-HARM).

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

Molina will follow up with Members 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 coordinating and directing services for the Member. The case manager provides the PCP with the Member's Individualized Care Plan (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 (Individual Care Plan) that includes recommended interventions from Member's ICT, (Integrated Care Team) 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:

- Assess 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 the member's needs warrant.

- Serves as a coordinator and resource to the Member, their representatives, 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 their needs. Level 1 Members can be engaged in the program for up to 90 days, depending on Their 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 various health conditions. The 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 and Identification and Stratification. You can also directly refer Members who may benefit from these program offerings via email at MHWCMReferrals@Molinahealthcare.com. Members can request to be enrolled or disenrolled in these programs at any time. The chronic conditions programs include:

- Asthma
- Depression
- Diabetes
- COPD
- Heart Failure
- Hypertension

Molina healthy lifestyle programs include:

- Weight Management
- Tobacco Cessation
- Nutrition consult

For more information about these programs, please call (833) 269-7830 (main line) or (866) 472-9483 (health lifestyle programs), TTY/TDD: 711 or fax at (800) 642-3691.

Maternity Screening and High-Risk Obstetrics

Molina offers to all pregnant Members prenatal health education with resource information as appropriate and screening services to identify high-risk pregnancy conditions. Care managers with specialized OB training provide additional care coordination and health education for Members with identified high-risk pregnancies to ensure the 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 pregnancy/high-risk pregnant Members via faxed Pregnancy Notification Report Forms.

Member Newsletters

Member Newsletters are posted on the Molina Healthcare website at least once a year. The articles cover topics asked by Members and offer tips to help Them stay healthy.

Member Health Education Materials

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

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 materials, 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 the following:

- Pharmacy Claims data for all classifications of medications.
- Encounter Data or paid Claims with a relevant CMS-accepted diagnosis or procedure code.
- Member Services welcomes staff calls to new Member households, and incoming Member calls can potentially 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 Provider(s), 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 Member newsletter or other Member communications.

Provider Participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease.
- Clinical resources such as patient assessment forms and diagnostic tools
- Patient education resources
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs.
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Case management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on health management programs is available from your local Molina Healthcare Services department.

Primary Care Providers

Molina provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine, and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina. Molina's Members are required to see a PCP who is part of the Molina Network. Molina's Members may select or change their PCP by contacting Molina's Member Support Center.

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.

Molina will help 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 executing 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 ensure 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 complete an assessment with the member upon engagement after identification for ICM enrollment and assist with the arrangement of individual services for members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina care manager is responsible for assessing the member's appropriateness for the ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

Referral to Care Management

Members with high-risk medical conditions and/or other care needs may be referred by the their PCP, specialty care provider, themselves, caregiver, discharge planner, or Molina Healthcare Services 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, ancillary providers, the local Health Department, or other community-based resources when identified. The referral source should be prepared to provide the care manager with demographic, health care, and social data about the Member being referred.

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

- High-risk pregnancy, including Members with a history of a previous preterm delivery.
- Catastrophic or end-stage medical conditions (e.g., neoplasm, organ/tissue transplants, End Stage Renal Disease)
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF, etc.)
- Preterm births
- High-technology home care requiring more than two (2) weeks of treatment.
- Member accessing emergency department services inappropriately.
- Children with Special Health Care Needs

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

Phone: (855) 322-4082
Fax: (800) 767-7188

Transitions of Care

During episodes of illness involving multiple care settings, patients are at increased risk of poor health outcomes and avoidable re-admissions resulting from fragmented care if care transitions

are not well executed. Molina designed its person-centered Transitions of Care (ToC) program to improve the quality of care for Members with complex physical, long-term, and behavioral health care needs as they transition across care settings. ToC programs have been shown to reduce preventable re-admissions and emergency department use and to improve health outcomes.

Molina defines ToC to include all services required to ensure the timely coordination and continuity of care from one care setting to another in accordance with Member's treatment progression and discharge readiness. This includes Member discharged from medical, psychiatric, and substance use disorder (SUD) inpatient treatment facilities and others. Molina's ToC team will confirm and establish or re-establish the patient's connection to their medical home/ PCP/specialist and assist with the coordination of care as the patient moves from one care setting to another. The target populations for Molina's ToC program are patients who are at a high risk of readmission, based on medical literature, predictive modeling, and risk stratification tools. Identified care settings that are supported in the ToC program include but are not limited to:

- Hospital/Acute Care
- Inpatient Psychiatric facilities/centers
- Long Term Acute Care
- Skilled Nursing Facility
- Rehabilitation Facility

Molina's ToC program focus is person-centered collaborative care coordination. Our Transitions team works closely with care management, discharge planners, health home staff, community health workers, pharmacy, Providers, and caregivers. This proactive collaboration helps assess and remove barriers prior to discharge. This interdisciplinary approach ultimately results in improved health outcomes and reduced readmissions. The ToC team provides oversight to ensure appropriate collaboration and confirms the Member's identified needs have been addressed. Weekly care review meetings led by a Molina medical director allow for discussion and planning for complex and difficult transitions.

Molina Members may be contacted by a ToC Coach via a face-to-face or telephonic visit while in the inpatient setting. The ToC Coach with the facility care team works to develop an individual care transition plan. The Member will receive a call within two (2) to three (3) business days after discharge. The ToC Coach will assess the Member's ability to make and attend all needed follow-up appointments, complete medication reconciliation, nutrition management, patient's understanding of illness and how to recognize worsening symptoms, when to call their PCP, and encourage the use of a health journal, assess home safety, the Member's support network and community connections, and will assist the Member with obtaining immediate psychosocial needs such as food, transportation, clothing, social support, advocacy, and other community-based resources.

The ToC may continue to provide care coordination for up to 30 days, based on the Member's needs and preferences. During each follow-up contact, primarily performed via telephone, the ToC coach ensures that the goals of the ICP have been met and the Member has successfully transitioned to a lower level of care. As the ToC process nears completion, Molina's ToC coach will identify any ongoing needs that a Member may have and, if needed, coordinate a referral to the Molina case management program or PCP who will work with the Member to address those needs going forward.

Molina's standard of care for ToC includes the following and requires these elements be completed by the facilities, PCP, Molina contracted staff, care managers, or Molina ToC coach for each Member as they transition between care settings.

- Assess and stratify Members into levels of risk to target Members at higher risk of readmission.
- Create an individual care plan to mitigate readmission to include:
    - Health education to support discharge care needs, for example, medication management, ensuring follow-up appointments are attended, self-management of conditions, and when and how to seek medical care. Care planning is to include caregivers as needed.
- At the time of discharge, written discharge plans must be given to Members, their treating Providers, and/or their caregivers based on Member needs and preferences to ensure timely access to follow-up care post-discharge and identify and re-engage Members who do not receive post-discharge care at the time of discharge.
- Member will receive medication education and be amenable to medication regimen at the time of discharge.
- Member will be provided an adequate supply of medications and/or prescriptions at discharge that will cover the days until their first prescriber appointment. Prescriptions will be sent to the pharmacy of Member's choosing.
- Organize post-discharge services, home care services, after-treatment services, and therapies, including SUD, etc.
- Telephonic reinforcement of discharge plan and needed problem-solving within two (2) to three (3) business days from the time of discharge.
- Information on what to do if a problem arises following discharge including how/when to access emergency care and crisis services.
- For patients at high risk of re-hospitalization, a visit by the PCP or care coordinator at the facility before discharge to coordinate the transition.
- Ensure Members have an in-person PCP, behavioral health, home health, or specialty Provider appointment within seven (7) calendar days of discharge to support discharge instructions, assess environment safety, conduct medicine reconciliation, assess the adequacy of support network and services, and link to appropriate referrals.
- Arrange for discharge transportation and discharge aftercare appointments as needed.

In addition to the above the following are also requirements for inpatient SUD ToC:

- If the Member was treated with FDA-approved medications for SUD during their stay, the Member will be discharged with a same-day appointment for Medication Assisted Treatment (MAT) to ensure continuation of treatment.
- Provide the Member with contact information for community-based peer support and recovery support services.
- Member's housing must be
  - Verified and documented within the electronic health record,
  - Referred to housing and community support services as needed, and
  - Location of MAT services taken into consideration as applicable.

Health Home Services

Please note health home services are only available for Apple Health Medicaid Members. They are not available to AHE Members.

Health home implementation is authorized by Section 2703 of the federal Patient Protection and Affordable Care Act, the managed fee-for-service demonstration model, and the Substitute Senate Bill 5394 from the 2011 legislative session. Under Washington State's approach, health homes (HH) are the bridge to integrate care within existing health delivery systems.

A Health Home is the central point for directing person-centered care for high-risk, high-cost Members in a specified geographic coverage area. The Health Home is accountable for reducing avoidable healthcare costs, specifically preventable hospital admissions/re-admissions, and avoidable emergency room visits. The Health Home will provide timely post-discharge follow-up with the goal of improving Member outcomes by providing intensive care coordination services to high-cost, high-need Medicaid and Medicaid/Medicare Members to ensure that services are integrated and coordinated across medical, mental health, chemical dependency, long-term services and supports and community support services.

Molina is a qualified Health Home (AKA "lead entity") For IMC and FFS, for geographic area 1 (Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, and Thurston Counties); area 2 (Island, San Juan, Skagit, and Whatcom Counties); area 3 (King); area 4 (Pierce); area 5 (Clark, Klickitat, Skamania, Cowlitz, and Wahkiakum); area 6 (Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman Counties) and area 7 (Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin. In January 2023 Molina added Health Homes as a benefit to our Apple Health Medicare Connect (formerly DSNP) As a qualified lead entity, Molina is responsible for providing (or contracting for) the following six (6) specific care coordination services functions:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitions of care from inpatient to other settings, including appropriate follow-up

- Individual and family support, including authorized representatives
- Referral to community and social support services

As a lead entity, Molina has created integrated provider networks in the above areas to ensure physical health, mental health, chemical dependency, long-term services, and social support needs can be met through an integrated collaborative approach.

Molina is contracted with numerous community-based Care Coordination Organizations (CCOs). The CCO supports a team of care coordination staff responsible for delivering face-to-face interactions with eligible Health Home enrollees. Molina provides direct services as a CCO and employs a state-wide network of care coordinators.

The Molina Health Home staff is a combined team of care coordinators and community health workers. The dedicated care coordination staff provides individual enrollee interactions aimed at delivering six (6) Health Home elements of care coordination (see previous description).

HCA determines eligibility for the Members who are passively enrolled. Those determined eligible for Health Homes must have at least one (1) chronic condition, be at risk for a second, and have a minimum predictive risk score (PRISM) of 1.5.

Members could consent or opt-into the Health Home services and withdraw by opting out of Health Home services.

The care coordinator will be responsible for informing and coordinating services with a Member's current medical team as needed and will support the Member in receiving other community support services. When your client receives Health Home services, the care coordinator will notify you by communicating the Health Action Plan to the PCP. This is an assessment and care plan that outlines the Member's goals.

If you would like more information about Molina's Health Home program, email your questions to wahealthhomes@molinaheathcare.com.

8. BEHAVIORAL HEALTH

Overview

Molina provides a behavioral health benefit for Members. It takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health providers, and other specialty Providers to ensure whole-person care. Molina complies with the most current Mental Health Parity and Addiction Equity Act requirements. 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

For additional information please refer to the Prior Authorization subsection found in the Health Care Services section of this Provider Manual.

Some behavioral health services may require prior authorization.

Behavioral health inpatient, substance use disorder residential services, psychiatric residential treatment, and select outpatient treatment(s) can be requested by submitting an admission notification/prior authorization form or contacting Molina's prior authorization team at (855) 322-4082. Providers requesting after-hours authorization for these services should utilize Availity Essentials portal or fax submission options. Molina strongly recommends the use of the Availity Essentials portal to submit ALL prior authorization requests.

Emergency psychiatric services do not require prior authorization. All requests for behavioral health services should include the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification as well as current clinical information supporting the request. Molina utilizes standard, generally accepted medical necessity criteria for prior authorization reviews.

The most current prior authorization guidelines and the Prior Authorization Request Form can be found on the Molina website at MolinaHealthcare.com .

Access to Behavioral Health Providers and PCPs

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

self-refer or be referred to a PCP, specialist, or behavioral health Provider. However, individual services provided by non-network behavioral health Providers will require prior authorization.

Behavioral health providers may refer members to in-network primary care providers (PCPs), or members may self-refer. Members can also be referred to PCPs and specialty care providers to address their health care needs. If a behavioral health provider identifies additional health concerns—including physical health concerns—these 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 and to occur within seven (7) days the of discharge date.

Interdisciplinary Care Coordination

To provide care for the whole person, Molina emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral health, primary care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase the communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunities for optimal health outcomes. Molina's care management program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Care Management

Molina's care management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and/or substance use disorder (SUD) needs. Members with high-risk psychiatric, medical, or psychosocial needs may be referred by a behavioral health professional or PCP to the care management program.

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

Email: MHWCMReferrals@Molinahealthcare.com
Phone: (855) 322-4082
Fax: (800) 867-7188

For 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.

Behavioral Health Care Management

Access to Records and Information to Support Member Care Coordination and Care Management Activities

Molina is committed to working with its Providers to address the care coordination and care management needs of its members. To facilitate such activities, all Providers (including substance use disorder providers and behavioral health providers) are required to cooperate with and provide Molina any and all relevant patient/member records and information requested by Molina to support such activities. To the extent a consent and/or authorization from the patient/member is required by law to disclose the requested records/information to Molina, the Provider shall make best efforts to obtain the necessary consent(s) and/or authorization(s) from the patient/member.

Both Molina and the Provider agree to comply with HIPAA and other applicable federal and state privacy laws and regulations including, but not limited to, the HIPAA privacy regulations set forth in 45 C.F.R. Part 164 Subpart E, the HIPAA security regulations set forth in 45 C.F.R. Part 164 Subpart C, 42 C.F.R. Part 2 Regulations governing the Confidentiality of Substance Use Disorder Patient Records and state-specific medical privacy laws.

Responsibilities of Behavioral Health Providers

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

Providers shall follow quality standards related to access. Molina provides oversight of Providers to ensure Members can obtain needed health services within acceptable appointment timeframes. Please refer to the Quality section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven (7) days of the discharge date. If a Member misses a behavioral health appointment, the behavioral health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Line

Molina has a Behavioral Health Crisis Line that Members may access 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 support, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling (800) 869-7175.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone with concerns about someone else), can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year, by dialing 988 from any phone.

Behavioral Health Tool Kit for Providers

Molina has developed an online Behavioral Health Tool Kit to support screening, assessment, and diagnosis of common behavioral health conditions. The kit also provides access to behavioral health HEDIS® Tip Sheets and other evidence-based guidance, training opportunities for Providers, and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both medical care and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the "Health Resources" tab on the Washington Providers Home (molinahealthcare.com) Provider website.

Infant Early Childhood Mental Health

Providers conducting a mental health assessment (i.e., Psychiatric Diagnostic Evaluation or Intake Evaluation) with children from birth through age five can be reimbursed for up to five sessions per billing provider, per client, per calendar year, without prior authorization.

Apple Health mental health professionals conducting a mental health assessment for a childbirth through age 5 are required to use the DC:0 - 5. The Apple Health DC:0-5™ Crosswalk is a tool that helps Apple Health providers 'crosswalk' DC:0-5 diagnoses to associated ICD-10-CM diagnostic codes, which are required for Apple Health billing purposes. Free DC:0-5 training for Apple Health providers is available through the Infant-Early Childhood Mental Health Workforce Collaborative (IECMH-WC).

The HCA MHAYC webpage provides guidance on billing and clinical policy for MHAYC, including regular billing webinars and more. The HCA IECMH webpage provides additional guidance on billing and clinical policy for infant-early childhood mental health (IECMH) services, including quarterly IECMH Office Hours, the IECMH Services toolkit, and more.

Behavioral Health Practitioner Travel Reimbursement

Effective January 1, 2022, Medicaid Behavioral Health providers are eligible for travel reimbursement related to Mental Health Assessments for Young Children (MHAYC). Providers should use their clinical judgment and family preference when determining if travel for conducting a mental health assessment is necessary. Providers are eligible for travel reimbursement under a specific set of circumstances:

- Must be traveling to conduct a mental health assessment; and
- Must conduct a mental health assessment for a child under six (6) years of age; and
- Must conduct a mental health assessment in the child/family's home or in a community setting; and
- Must use the DC: 0-5 diagnostic classification system.

Providers are eligible for travel reimbursement for up to five (5) sessions to administer a MHAYC, if necessary. Funds for reimbursement are available until the pool of money is depleted.

Providers must complete and submit the following forms for reimbursement:

- W9
- Molina's A-19
- Supplier Profile Form
- Molina's A-19 and Supplier Profile Form can be found at
- MolinaHealthcare.com/providers/wa/medicaid/forms/fuf.aspx.

Forms and invoices must be submitted to WA_Finance_IMC@molinahealthcare.com.

Claims must be submitted prior to invoice submission. Invoices will not be paid without an adjudicated Claim and invoices must be submitted no later than 60 days from supporting Claim.

The following information must be present on any submitted claims to qualify the claims for provider travel reimbursement.

- CPT®/HCPCS Code (90791, 90792, H0031)
- Client age (0 years up until 6th birthday)
- Place of Service Code (03: School, 04: Homeless Shelter, 12: Home, 99: Other Place of Service)

Claims with a U8 modifier, which identify services provided to Wraparound Intensive Services (WISe) participants by qualified WISe practitioners, are NOT eligible for MHAYC provider travel reimbursement.

Molina will process and reimburse Providers within ten (10) business days of submission.

For billing information go to hca.wa.gov/billers-providers-partners/behavioral-healthrecovery/mental-health-assessment-young-children. For additional information regarding RCW.74.09.520, go to app.leg.wa.gov/rcw/default.aspx?cite=74.09.520.

9. QUALITY

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement (QI) Program. You can email the Molina Quality Department at MHW_QI_Department@MolinaHealthcare.com.

The address for mail requests is:

Molina Healthcare of Washington, Inc.
Quality Department
P.O. Box 4004
Bothell, WA 98041-4004

This Provider Manual contains excerpts from the Molina QI program. For a complete copy of Molina's QI program, you can contact your Provider Relations representative or call the telephone number above to receive a written copy.

Molina has established a QI Program that complies with regulatory requirements and accreditation standards. The QI Program provides structure and outlines specific activities designed to improve the care, service, and health of our Members. In our QI 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 QI 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 designed to improve the quality of care and services and Member experience.
- Allow Molina to collect, use, and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability.
- Allow access to Molina Quality personnel for the site and medical record review processes.
- Coordinate medical record retrieval and submission with Molina Quality personnel upon request.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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 health practices for our Members through our safety program, pharmaceutical management and care management/health 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 the Department of Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

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

- Surgery on the wrong body part.
- Surgery on the wrong patient.
- Wrong surgery on a patient.
- Molina is not required to pay for inpatient care related to "never events."

Medical Records

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

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

Medical Record Keeping Practices

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

- Each patient has a separate medical record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available during each visit and archived records are available within 24 hours.
- If hard copy, pages are securely attached to the medical record, and records are organized by dividers or color-coded when the thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for quality and HIPAA compliance, including the privacy of confidential information such as race, ethnicity, language, sexual orientation, and gender identity.
- Storage maintenance for the determined timeline and disposal per record management processes.
- The process is in place 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, but not be limited to the following information:

- The patient's name or ID number on each page in the record.
- The patient's name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of the Provider and other staff members within a paper chart.
- A list of all Providers who participate in the Member's care.
- Information about services that are delivered by these Providers.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 30 days of an inpatient discharge with evidence of current and discharge medication reconciliation and the date performed.

- Allergies and adverse reactions (or notation that none are known). Documentation that shows advance 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 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 that include the specific time of return are noted in weeks, months, or as needed, and included in the next preventative care visit when appropriate.
- Notes from consultants as applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow-up plan(s).
- All ancillary services report.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions and follow-up care, inpatient, and outpatient care, including hospital discharge summaries, hospital history, and physical and operative reports.
- Labor and delivery record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.
- A release document for each Member authorizing Molina to release medical information for the 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 their request.
- A storage system for inactive Member medical records that allows retrieval within 24 hours, is consistent with state and federal requirements and maintains the record for not less than ten (10) years from the last date of treatment or, for a minor, one (1) year past their 20th birthday but never less than ten (10) years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

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

Ensure that medical information is released only in accordance with applicable federal or state law in pursuant to court orders or subpoenas.

- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertains to them.
- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Protect medical records from unauthorized access.
- Restrict access to computerized confidential information.
- Take precautions to prevent inadvertent or unnecessary disclosure of protected health information.
- Educate and train all staff on handling and maintaining protected health care information.
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity, and social determinants of health.

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

Advance Directives (Patient Self-Determination Act)

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

Advance directives are a written choice for health care. There are two (2) types of advance directives:

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

When there is no advance directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult Molina Members, 18 years old and up, of their right to make health care decisions and execute advance directives. It is important that Members are informed about advance directives.

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

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

Molina network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. If the assigned provider objects to the member's desired decision, members may select a new PCP. 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 regulations give 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 directive 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 an Advance Directive in a prominent medical record location. Advance directive forms are state specific to meet state regulations.

Molina expects documented evidence of the discussion between the Provider and the Member during routine medical record reviews.

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include PCPs (family/general practice, internal medicine, and pediatric), OB/GYN (high-volume specialists), Oncologist (high-impact specialists), and behavioral health Providers. Providers must conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment Access

All Providers who oversee the Member's health care are responsible for making the following appointments to Molina Members within the timeframes noted by our regulators, HCA and NCQA.

Medical Appointment

Appointment Types	Standard
Routine, asymptomatic (i.e., nonsymptomatic/preventive care)	Within 30 calendar days
Appointment Types	**Standard**
Routine, symptomatic (i.e., non-urgent)	Within 10 calendar days
Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 days/week availability
Specialty Care (High Impact/High Volume)	Within 30 calendar days
Emergency Services	24 hours per day 7 days per week
Transitional Health Care Services by a PCP	Within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program
Transitional Health Care Services-by a Home Care Nurse, Home Care Mental Health Professional or other Behavioral Health Professional	Transitional health care by a home care nurse, home care mental health professional, or behavioral health professional within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health, if ordered by the Member's PCP or as part of the discharge plan.

Behavioral Health Appointment

Appointment Types	Standard
Emergency Services	Immediately (24 hours per day 7 days per week)
Non-life Threatening Emergency	Within 6 hours
Urgent Care	Within 24hours
Initial Routine Care Visit	Within 10 calendar days
Follow-up Routine Care Visit (Prescriber)	Within 30 calendar days
Follow-up Routine Care (Non-Prescriber)	Within 20 calendar days

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

Office Wait Time

The wait time in offices for scheduled appointments should not exceed 30 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

All Providers must have backup (on-call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, 7 days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after hours is not acceptable.

Women's Health Access

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

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

Monitoring Access for Compliance with Standards

The Quality Improvement and Health Equity Transformation Committee reviews, revises as necessary, and approves access to care standards on an annual basis.

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

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

Analysis of access data includes assessing performance against established standards, reviewing trends over time, and identifying barriers. The results of the analysis are reported to the Quality Improvement and Health Equity Transformation 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 and Health Equity Transformation 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 for an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety, and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical Accessibility
- Physical Appearance
- Adequacy of Waiting and Examining Room Space

Physical Accessibility

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

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

During the site visit as required, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodation 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 overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and the 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 (2) office exam rooms per Provider.
- Basic emergency equipment is in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one (1) CPR-certified employee is available.
- Yearly Occupational Safety and Health Administration (OSHA) training (fire, safety, bloodborne pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is in each room where injections are given.
- Labeled containers, policies, contracts, and evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Alternative methods include signatures on fee slips, separate forms, stickers, or labels.
- 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.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.

- Drug refrigerator temperatures are documented daily.

EPSDT Services to Enrollees Under 21 Years of Age

Please note EPSDT requirements apply to the Medicaid Apple Health Population ONLY. They do not apply to the Apple Health Expansion population.

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

Well Child/Adolescent Visits

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

- Comprehensive health and developmental history
- Nutritional assessment
- Height and weight and growth charting
- Comprehensive unclothed physical examination
- Appropriate immunizations according to the Advisory Committee on Immunization Practices
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool.
- Vision screening for preventive services. Only medically necessary services are covered. Pediatric routine vision services (one [1] eye exam per year) is accessed by Members through the VSP network.
- Hearing screening for preventive services
- Dental assessment and services
- Health education, including anticipatory guidance on topics 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 benefits 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 outlined above at least annually. Performance below Molina's standards may result in a corrective action plan (CAP), with a request that the Provider submit a written CAP 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 QI Program. The program provides structure and key processes to carry out our ongoing commitment to improving care and service. Through the QI program, Molina focuses on reducing health care disparities. 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 refer to the Health Management and Care Management subsections in the Health Care Services section of this Provider Manual.

Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPG) to reduce inter-provider variation in diagnosis and treatment. CPG adherence is measured at least annually. CPGs are based on scientific evidence, review of medical literature, and/or appropriately established authority.

Molina CPGs include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- HIV/AIDS
- Heart Failure in Adults
- Homelessness-Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Prevention
- Trauma-Informed Primary Care

CPGs are updated at least annually and more frequently as needed when clinical evidence changes. They are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis, or when changes are made during the year, CPGs are distributed to Providers at Clinical Practice Guidelines (MolinaHealthcare.com) (or when changes are made during the year) and the Provider Manual. Notification of the availability of the CPGs is published in the Molina Provider Newsletter.

Preventive Health Guidelines

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

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on Molina's website.
- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of Pediatrics). Molina's website includes links to current recommendations.

- Recommended Adult Immunization Schedule for ages 19 Years or older (United States). The CDC revises these recommendations every year. Molina's website includes links to current recommendations.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on Molina's website.

All preventive health guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis, or when changes are made during the year, preventive health guidelines are distributed to Providers at MolinaHealthcare.com/providers/wa/medicaid/resource/guide_prevent.aspx and the Provider Manual. Notification of the availability of the preventive health guidelines is published in the Molina Provider Newsletter.

Culturally and Linguistically Appropriate Services

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina's program and services please refer to the Culturally and Linguistically Appropriate Services section of this Provider Manual.

Measurement of Clinical and Service Quality

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

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

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

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

Molina's most recent results can be obtained from your local Molina Quality department or by visiting our website at MolinaHealthcare.com/providers/wa/medicaid/home

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes 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 various ways. They evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation for measuring the effectiveness of these programs.

Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations. The data are also used to compare against established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is the tool used by Molina to summarize Medicaid Member satisfaction with Providers, health care, and the services they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care, and Getting Needed Prescription Drugs (for Medicare). The CAHPS® survey is administered annually in the spring to randomly selected Members by an NCQA-certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Behavioral Health Satisfaction Assessment

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

Provider Satisfaction Survey

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

Effectiveness of Quality 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 ongoing assessment of clinical and service improvements. The results of these measurements guide activities for successive periods.

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

What Can Providers Do?

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

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

Critical Incident Reporting

What is a Critical Incident?

- Critical Incidents are traumatic. When one of our members experiences a Critical Incident (CI), Molina is responsible for following up to ensure they have the care they need.
- CIs are reported to HCA by Molina through semi-annual reporting and 24-hour notification to the HCA Incident Reporting System.
- To provide follow-up, it is important that our external Provider network reports CIs to Molina as soon as the incident has been identified.

Critical Incident Reporting Criteria

1. The following are critical incidents that need to be reported per HCA.
    a. Incidents that occurred **to** a Member while they were within a contracted behavioral health facility, FQHC, or by an independent Provider.
        i. Abuse, neglect, or sexual/financial exploitation perpetrated by staff.
        ii. Physical or sexual assault perpetrated by another individual
        iii. Death
        iv. Severely adverse medical outcome or death occurring within 72 hours of transfer from a contracted behavioral facility to a medical treatment setting.
    b. Incidents that occurred **by** a Member (allegedly committed the following) – Member must have a current behavioral health diagnosis or history of behavioral health treatment within the previous 365 days.
        i. Homicide or attempted homicide
        ii. Arson
        iii. Assault or action resulting in serious bodily harm which has the potential to cause disability or death.
        iv. Kidnapping
        v. Sexual assault
    c. Other critical incidents that need to be reported:
        i. Unauthorized leave from a behavioral health facility during an involuntary detention
        ii. Any event that has or will attract media attention – including a link to the media source in the description.
        iii. Any incident posing a credible threat to the Member's safety.
        iv. Any suicide attempts.
        v. Poisoning/overdose – unintentional or intention unknown

NOTE: HCA has recently announced that child abuse cases are no longer required to be reported to the Medicaid MCOs such as Molina through the critical incident process but rather are reported directly to the Children's Administration/CPS as part of mandatory reporting requirements. The intent is to reduce the burden of reporting and eliminate duplicative

reporting as much as possible. However, if the incident also falls under one of the additional critical incident reporting criteria outlined here, it must be reported through Molina's critical incident process.

If you have any questions, please contact us at MHW_Critical_Incidents@MolinaHealthcare.com.

What a Critical Incident is NOT:

- Threatening suicide or suicidal ideation (thinking about it)
- Routine car accidents not resulting in a serious injury.
- Accidents-minor not resulting in a serious injury.

How do I report a Critical Incident?

- As soon as you are notified of the critical incident
- Ensure Member safety first, then report

Critical Incidents should be reported regardless of member's coverage (Medicaid, BHSO, AHE). Some critical incidents require notification to HCA within one business day of Molina's notification, so it is important that you report to Molina as soon as possible.

Molina's Critical Incident form can be found at MolinaHealthcare.com. Email the completed Critical Incident form to Molina at: MHW_Critical_Incidents@MolinaHealthcare.com. If secure email is not available, you can fax the form to (800) 767-7188 "Attn: Case Management."

10. RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

CMS defines risk adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

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

Interoperability

The 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 Provider's Electronic Medical Records (EMR), including, but not limited to, Epic Payer Platform, Direct Protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource).

The 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.

The 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.

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

- If the Provider does not have a Direct Address, it will work with its EMR vendor to set up a Direct Messaging Account, which also supports the requirement of having the Provider's Digital Contact Information added in NPPES.
- If the Provider's EMR does not support the Direct Protocol, the Provider will work with Molina's established interoperability partner to establish an account.

The Provider's role

As a Provider, complete and accurate documentation in a medical record is critical to a Member's quality of care. Providers are encouraged to record all diagnoses to the highest specificity. This will ensure Molina receives adequate resources to provide quality programs to Providers and Molina Members.

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

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

Contact Information

For questions about Molina's risk adjustment programs, please contact your Molina Provider Services representative.

11. COMPLIANCE

Fraud, Waste and Abuse

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

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from recurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse to reduce health care costs 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 the falsity of information in the Claim.
- Acts in deliberate ignorance of the truth or falsity of the information in a Claim; or,
- Acts in reckless disregard of the truth or falsity of the information in a Claim.

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

Deficit Reduction Act

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

As a contractor doing business with Molina, Providers, and their staff have the same obligation to report any actual or suspected violation or 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
- Administrative remedies for false Claims and statements

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 (2) times the amount of back pay plus interest.
- Compensation for special damage incurred by the employee because of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the law. Healthcare entities (e.g., providers, facilities, delegates, and/or vendors) to which Molina has paid $5 million or more in Medicaid funds during the previous federal fiscal year (October 1-September 30) will be required to submit a signed "Attestation of Compliance with the Deficit Reduction Act of 2005, Section 6032" to Molina.

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

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

referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

Molina conducts all business in compliance with federal and state AKS statutes and regulations and federal and state marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

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

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

Marketing Guidelines and Requirements

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

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

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

Stark Statute

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

Sarbanes-Oxley Act of 2002

The Sarbanes-Oxley Act 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: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 CFR § 455.2).

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

Abuse means 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 costs to state and federal health care programs (42 CFR § 455.2).

Examples of Fraud, Waste, and Abuse by a Provider

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

- A Provider knowingly and willfully refers 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 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 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 Member ID card.

- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding to receive or maximize reimbursement.
- Inappropriate billing of modifiers to receive or maximize reimbursement.
- Inappropriately billing a procedure that does not match the diagnosis to receive or maximize reimbursement.
- Knowingly and willfully solicit or receive payment of kickbacks or bribes in exchange for referring patients.
- Not following incident-to-billing guidelines 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 to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered and instead uses a code for a like service that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

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

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud state and federal health care programs.
- Doctor shopping, which occurs when a Member consults several Providers to obtain services inappropriately.
- Falsifying documentation 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 Claim System

Molina Claims examiners are trained to recognize unusual billing practices, which is key in identifying fraud, waste, and abuse. If the Claims examiner suspects fraudulent, abusive, or wasteful billing practices, they document them and report them to the SIU through our Compliance Alertline/reporting repository.

The Claim payment system utilizes system edits and flags to validate that claim elements 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 the implementation of Claim edits, Molina's Claim payment system is designed to audit Claims concurrently to detect and prevent inappropriate Claims from being paid.

Molina has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to state and federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, CMS, federal guidelines, AMA, and published specialty-specific coding rules. Code edit rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, 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 the Provider can provide sufficient accurate support.

Post-payment Recovery Activities

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

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall, in its sole discretion, exercise

the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under law and equity, or some combination thereof.

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

If a Molina auditor is denied access to the Provider's records, all the Claims for which the Provider received payment from Molina are immediately due and owing. If the 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 the Provider. The Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which the Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

The Provider acknowledges that HIPAA specifically permits a covered entity, such as the Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 164.501). The Provider further acknowledges that to receive payment from Molina, the 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 the 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.

The Provider acknowledges Molina's right to conduct pre-and post-payment billing audits. The Provider shall cooperate with Molina's SIU and audits of Claims and payments by providing access at reasonable times to requested Claims information the Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. 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 reserves the right, where unprohibited by regulation, to select a statistically valid random sample or a 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 extrapolated 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 maybe vendor-assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan, and copy all records necessary to determine compliance and accuracy of billing.

If Molina's SIU 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.

Provider Education

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

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a CAP to Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste, and Abuse

Suspected cases of fraud, waste, or abuse must be reported to Molina by contacting the Molina Alertline. The Molina Alertline is an external telephone and web-based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. The Molina Alertline telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year. When a report is made, callers can choose to remain confidential or anonymous. When calling the Molina Alertline, a trained professional at NAVEX Global will note the caller's concerns and provide them to the Molina Compliance department for follow-up. When electing to use the web-based reporting process, a series of questions will be asked concluding with the submission of the report. Reports to the Molina Alertline can be made from anywhere within the United States with telephone or internet access.

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

Fraud, waste, or abuse cases may also be reported to Molina's Compliance department anonymously without fear of retaliation.

Molina Healthcare of Washington, Inc.

Attn: Compliance
PO Box 4004
Bothell, WA 98041-4004

Remember to include the following information when reporting:

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

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

Washington Health Care Authority
Attn: Office of Program Integrity
P.O. Box 45503
Olympia, WA 98504-5503
Toll-Free Phone: (800) 562-6906
Fax: (360) 586-0212
Online: Fraud prevention | Washington State Health Care Authority

Office of the Attorney General
Attn: Medicaid Fraud Control Division
PO Box 40114
Olympia, WA 98504

Phone: (360) 586-8888
Fax: (360) 586-8888
Online: hca.wa.gov/about-hca/medicaid-fraud-prevention

HIPAA Requirements and Information

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

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

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

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

Applicable Laws

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

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

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

Artificial intelligence

The Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input, or prompt, as applicable, make predictions, recommendations, data sets, work products (whether eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to Molina Members including, but not limited to utilization management, prior authorizations, complaints, appeals, and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician.

In addition, the Provider shall not use AI-generated voice technology, including but not limited to AI voice bots, voice cloning, or synthetic speech systems to initiate or conduct outbound communications to Molina. The prohibition includes, but is not limited to, communications for billing, eligibility verification, prior authorization, or any other administrative function.

Notwithstanding the foregoing, the Provider shall give advance written notice to your Molina Contract Manager (for any AI used by the Provider that may impact the provision of Covered Services to Molina Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by Molina, the Provider further agrees to (i) allow Molina to audit Providers' AI use, as requested by Molina from time to time, and (ii) to cooperate with Molina regarding any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Molina Members.

If you have additional questions, please contact your Molina Contract Manager

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 their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities but also to the TPO of another covered entity[1] . Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

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

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

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

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

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

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records under 42 USC § 290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2") apply to any entity or individual providing federally assisted alcohol or drug abuse prevention treatment. "SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 CFR Part 2. Providers that are Part 2 Programs must comply with the requirements of 42 CFR Part 2, as amended from time to time.

SUD Records are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, CFR Part 2 is more restrictive than HIPAA and does not allow disclosure without the patient's written consent except as set forth in 42 CFR Part 2. Any disclosure of SUD Records to Molina with the written consent of the patient, by a Provider that is a Part 2 Program, must meet the notice requirements of 42 CFR Part 2, specifically Sections 2.31 and 2.32, and shall include a copy of the patient's consent or a clear explanation of the scope of the consent provided. Providers that are Part 2 Programs pursuant to 42 CFR Part 2 must promptly inform Molina that they are a Part 2 Program.

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 to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction, and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written Authorizations

Uses and disclosures of PHI 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 covered under HIPAA and having a direct treatment relationship with patients 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, billing, and other records used to make decisions about the Member's care or payment for care.

5. **Request to Amend PHI**

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

6. **Request Accounting of PHI Disclosures**

   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6)-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations.

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 maintained appropriate cybersecurity measures. Providers should recognize that identity theft—both financial and medical—is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

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

HIPAA Transactions and Code Sets

Molina strongly supports the use of electronic transactions to streamline health care administrative activities. Molina Providers are encouraged to submit Claims and other

transactions to Molina using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

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

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

1. Click the tab titled "HIPAA"
2. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets."

Code Sets

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

National Provider Identifier (NPI)

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

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

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

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review

- Resolution of an Appeal and/Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment, and/or Operation Purposes
- Collection of HEDIS® medical records

Information Security and Cybersecurity

NOTE: This section (Information Security and Cybersecurity) applies only to Providers who have been delegated by Molina to perform a health plan function(s) and in connection with such delegated functions.

1. Definitions:
   a. "Molina Information" means any information: (i) provided by Molina to Provider; (ii) accessed by Provider or available to Provider on Molina's Information Systems; or (iii) any information with respect to Molina or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Molina Nonpublic Information.

   b. "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition, or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized, or unlawful destruction, loss, alteration, use, disclosure of, or access to Molina Information. For clarity, a Breach or Security Incident, as these terms are defined under HIPAA, constitutes a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition, or disclosure of Molina Information, or sustained interruption of service obligations to Molina.

   c. "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

   d. "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

   e. "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards,

relating to the security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time, and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

i) HIPAA and HITECH
ii) HITRUST Common Security Framework
iii) Center for Internet Security
iv) National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1, or as currently revised
v) Federal Information Security Management Act ("FISMA")
vi) ISO/ IEC 27001
vii) Federal Risk and Authorization Management Program ("FedRamp")
viii) NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."
ix) International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

f. "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database, and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form.

g. "Multi-factor authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

h. "Nonpublic Information" includes:
i) Molina's proprietary and/or confidential information.
ii) Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and
iii) Protected Health Information as defined under HIPAA and HITECH.

2) Information Security and Cybersecurity Measures. Provider shall implement and always maintain appropriate administrative, technical, and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon, and Molina Information that is accessible to, or held by, Provider. Such measures shall conform to

generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical, and physical safeguards pursuant to HIPAA, HITECH, and other applicable U.S. federal, state, and local laws.

a) Policies, Procedures, and Practices. The provider must have policies, procedures, and practices that address its information security and cybersecurity measures, safeguards, and standards, including as applicable, a written information security program, which Molina shall be permitted to audit via a written request, and which shall include at least the following:
    i) Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and Molina Information accessible to or held by the Provider.
    ii) Encryption. Use of encryption to protect Molina Information, in transit and at rest, accessible to or held by Provider.
    iii) Security. Safeguarding the security of the Information Systems and Molina Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.
    iv) Software Maintenance. Software maintenance, support, updates, upgrades, third-party software components, and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.
b) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:
    i) Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include but are not limited to, the applicable Industry Standards.
    ii) Cloud Services Security: If the Provider employs cloud technologies, including Infrastructure as a Service (IaaS), Software as a Service (SaaS), or platform as a service (PaaS), for any services, Provider shall adopt a “zero-trust architecture” satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).
    iii) Data Storage. Provider agrees that all Molina Information will be stored, processed, and maintained solely on designated target servers or cloud resources. No Molina Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium unless that device or storage medium is in use as part of the Provider’s designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv) Data Encryption. Provider agrees to store all Molina Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees

v) that any and all Molina Information, stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

vi) Data Transmission. Provider agrees that all electronic transmission or exchange of system and application data with Molina and/or any other parties expressly designated by Molina shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vii) Data Re-Use. Provider agrees that all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of the Provider. Provider further agrees that no Molina Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors, or interested parties except on a case-by-case basis as specifically agreed to in advance and in writing by Molina.

3) Business Continuity ("BC") and Disaster Recovery ("DR"). The provider shall have documented procedures in place to ensure continuity of its business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade, or disrupt its delivery of services to Molina.

a) Resilience Questionnaire. Provider shall complete a questionnaire provided by Molina to establish Provider's resilience capabilities.

b) BC/DR Plan.

i) Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and Molina. The BC/DR Plan shall include the following:

(a) Notification, escalation, and declaration procedures.
(b) Roles, responsibilities, and contact lists.
(c) All Information Systems that support services provided to Molina.
(d) Detailed recovery procedures in the event of the loss of people, processes, technology, and/or third parties or any combination thereof providing services to Molina.
(e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.

(f) Detailed list of resources to recover services to Molina including but not limited to applications, systems, vital records, locations, personnel, vendors, and other dependencies.

(g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.

(h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to Molina. Such risk assessment shall evaluate natural, man-made, political, and cybersecurity incidents.

ii) To the extent that Molina Information is held by Provider, Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.

iii) Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

c) Notification. Provider shall notify Molina's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed 24 hours, of either of the following:

i) Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Molina or that detrimentally affects Provider's Information Systems or Molina's Information.

ii) Provider's activation of business continuity plans. Provider shall provide Molina with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue until normal services have been resumed.

d) BC and DR Testing. For services provided to Molina, the Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, the Provider shall provide Molina with a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified, and modifications to plans based on the results of the exercise(s).

4) Cybersecurity Events.

a) The Provider agrees to comply with all applicable data protection and privacy laws and regulations. The provider will implement best practices for incident management to identify, contain, respond to, and resolve Cybersecurity Events.

b) In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Molina Information accessible to or held by Provider, Provider shall notify Molina's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as

possible, but in no event later than 24 hours from Provider's discovery of the Cybersecurity Event.

i) In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within 24 hours following such payment.
ii) Within 15 days of such a ransom payment that involves or may involve Molina Information, the Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment, and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

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

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

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

d) In the event of a Cybersecurity Event, Provider will, at Molina's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Molina, (ii) fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers, and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law), and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Molina Information without the prior written consent of Molina.

e) Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation, or, upon request by Molina complete an investigation pursuant to the following requirements:
i) Decide as to whether a Cybersecurity Event occurred.
ii) Assess the nature and scope of the Cybersecurity Event.
iii) identify Molina's Information that may have been involved in the Cybersecurity Event; and
iv) perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of Molina Information.

f) The Provider must provide Molina with the following required information regarding a Cybersecurity Event 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 must include at least the following, to the extent known:
   i) the date of the Cybersecurity Event.
   ii) a description of how the information was exposed, lost, stolen, or breached.
   iii) how the Cybersecurity Event was discovered.
   iv) whether any lost, stolen, or breached information has been recovered and if so, how this was done.
   v) the identity of the source of the Cybersecurity Event.
   vi) whether the Provider has filed a police report or has notified any regulatory, governmental, or law enforcement agencies and, if so, when such notification was provided.
   vii) a description of the specific types of information accessed or acquired without authorization, which means data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer.
   viii) the period during which the Information System was compromised by the Cybersecurity Event.
   ix) the number of total consumers in each State affected by the Cybersecurity Event.
   x) 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.
   xi) a description of efforts being undertaken to remediate the situation that permitted the Cybersecurity Event to occur.
   xii) a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and
   xiii) the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of the Provider.

g) Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon Molina's request.

5) Right to Conduct Assessments, Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Molina performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement will be in compliance with generally recognized industry standards and

as provided in Provider's response to Molina's due diligence/security risk assessment questionnaire; (ii) agrees to inform Molina promptly of any material variation in operations from what was provided in Provider's response to Molina's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to Molina's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement.

6) Other Provisions. The Provider acknowledges that there may be other information security and data protection requirements applicable to It in the performance of services, which may be addressed in an agreement between Molina and the Provider but are not contained in this section.
7) Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between Molina and Provider, the stricter of the conflicting provisions will be controlled.

Washington State Health Care Authority Clinical Data Repository

HCA is advancing Washington's capabilities to collect, share, and use integrated physical and behavioral health information from provider's Electronic Health Record systems (EHRs) by implementing the Washington Link4Health Clinical Data Repository (CDR). The CDR aggregates clinical information from different EHRs in one easily accessible location. By providing access to clinical information from outside the enterprise, the CDR helps the care team gain a more comprehensive understanding of the patient's medical history. HCA has partnered with OneHealthPort to develop and manage the CDR. For more information and to learn more about the steps that need to be taken to participate in CDR please visit the HCA's CDR website, hosted by OneHealthPort at onehealthport.com/hca-cdr. Please also review HCA's flyer for information on the CDR at Clinical Data Repository One-pager (wa.gov).

Users can complete training in one (1) hour or less and reference materials are available on OneHealthPort's website.

Providers with certified EHRs who see Apple Health Managed Care members must send a Consolidated Clinical Document Architecture (CCDA) summary from their EHR to the CDR. Behavioral health providers are also encouraged to send CCDA from their EHR to the CDR. Substance use disorder providers are not required to submit CCDA to the CDR.
If you/your organization meet(s) the following criteria, you are required to participate in the CDR:

- Your organization is part of a Managed Care Organization that serves Apple Health consumers.
- Your organization has a 2014 certified EHR system; and,
- You have received monies from either the Medicare or Medicaid EHR Incentive Program

12. CLAIMS AND COMPENSATION

Payor ID	**38336**
Availity Essentials portal	**provider.molinahealthcare.com/**
Clean claim Timely filling	**180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services**

Electronic Claim Submission

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

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Availity Essentials portal.
- Submit Claims to Molina via your regular EDI clearinghouse.

Email address for clearinghouse assistance: EDI.CLAIMS@molinahealthcare.com

Availity Essentials portal

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

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) Claims with attached files.
- Correct/Void Claims.
- Add attachments to previously submitted Claims.
- Check Claims status.
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
- Create and manage Claim Templates.
- Create and submit a Claim Appeal with attached files.

Clearinghouse

Molina uses The SSI Group as its gateway clearinghouse. The SSI Group has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.
If you do not have a clearinghouse, Molina offers additional electronic Claims submission options, as shown by logging on to the Availity Essentials portal.

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

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgment from your clearinghouse.
- You should also receive a 277CA response file with the initial status of the Claims from your clearinghouse.
- You should refer to the Molina Companion Guide for information on the response format and messages.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

EDI Claim Submission Issues

Providers experiencing EDI Submission issues should work with their clearinghouse to resolve them. If the clearinghouse is unable to resolve the issue, the Provider should contact their Provider Relations representative for additional support.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by the Provider to Molina within 180 calendar days or as specified in your contract after the discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under the coordination of benefits or third-party liability, the Provider must submit Claims to Molina within 180 calendar days after the 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 the 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 through a clearinghouse or the Availity Essentials 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 Molina Member ID card. For more information, please refer to the Delegation section.

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

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed 30 calendar days from the change. Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Molina may validate the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data.

Per federal regulation (42.C.F.R. 455.410(b)), Providers who have a contract with the state's Medicaid agency or a contract with a Managed Care Organization (MCO) that serves Medicaid Clients must enroll with HCA under a Non-Billing or Billing agreement. The Provider's NPI submitted on all Claims must be the NPI registered with HCA.

Molina will deny/reject all Claims submitted to Molina for processing if billed with an NPI that is not enrolled with HCA, does not match what HCA identifies as the enrolled NPI number, or is not effective on the Claim's date of service.

For additional information and to access the Non-Billing and Billing and servicing enrollment form, which must be used to register with HCA or to correct an NPI, visit the HCA website at hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/enroll-provider.

Required Elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website at MolinaHealthcare.com under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate state

from the drop-down list at the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the state health plan-specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for compliance with Strategic National Implementation Process (SNIP) levels 1 to 5.

The following information must be included on every Claim, whether electronic or paper:

- 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 (anesthesia Claims require minutes)
- Provider tax identification number (TIN)
- 10-digit NPI or Atypical Provider Identifier (API)
- Rendering Provider information when different than billing
- Billing/Pay-to Provider name and billing address.
- Billing provider taxonomy
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), NCD Units, Units of Measure, and Days or Units for medical injectables
- E-signature
- Service Facility Location information
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and applies to atypical and out-of-state Providers.

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

EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission is required to follow electronic Claim standardized ASC X12N 837 formats. Electronic Claims are validated for Compliance with SNIP

levels 1 to 5. The 837 Claim format allows you to submit changes to Claims that were not included in the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "Claim frequency codes." Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace an entire Claim.	Molina will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Molina will void the original Claim from records based on request.

When submitting Claims noted with Claim frequency code 7 or 8, the most recent Claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 ERA. Without the original Claim number, adjustment requests will generate a compliance error, and the Claim will be rejected.

Claim corrections submitted without the appropriate frequency code will be denied as duplicates, and the original Claim number will not be adjusted.

Paper Claim Submission

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

Molina Healthcare of Washington, Inc.
PO Box 22612
Long Beach, CA 90801

When submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.

- Paper Claims are **required** to be submitted on original red and white CMS-1500 and CMS1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10 or 12-point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

Molina strongly encourages participating Providers to submit Corrected Claims electronically via EDI or the Availity Essentials portal.
All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- A corrected should reference the most recent claim number that is being replaced in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically. Reversal claims are not permitted as reference claims. If the claim number reference on a corrected is out of sequence (if it is not the most recent claim number), it will deny.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (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) for CMS-1450 (UB-04) Claim forms.

Corrected Claims must be sent within 24 months of the Date of Service or the most recent adjudicated date of the Claims remittance advice date.

Corrected Claims submission options:

- Submit Corrected Claims directly to Molina via the Availity Essentials portal.
- Submit corrected Claims to Molina via your regular EDI clearinghouse.

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

Third-party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, self-funded, commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina Members. If third-party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for the secondary Claim processing. If coordination of benefits occurs, the Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Molina will pay Claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third-party liability, an overpayment notification letter will be sent to the Provider requesting a refund, including third-party policy information required for billing.

Subrogation - Molina retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under state and federal law and the Member's benefit plan. If third-party liability is suspected or known, please refer pertinent case information to Molina's vendor:

Katch IQ:
Member Toll-Free Phone Number: 866-569-4685
Attorney/TPL carrier Phone Number: 888-870-8842
Attorney/TPL Fax Number: 877-200-0207
Referral Email: subrogationreferrals@katchiq.com
*(submitreferrals@optum.com is also still active and feeds into the @katchiq.com email)
Operating Hours: 7:00 a.m. to 7:00 p.m. CT Monday - Friday.
Member Investigation Response Website: https://selfservice.katchiq.com
*(https://subroresponse.optum.com is also still active)
Attorney Referral Website: https://subroreferrals.com

Hospital-Acquired Conditions (HAC) and Present on Admission (POA) 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 evidence-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting."

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:

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility

4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries
    e) Burn
    f) Other Injuries
6) Manifestations of Poor Glycemic Control
    a) Hypoglycemic Coma
    b) Diabetic Ketoacidosis
    c) Non-Ketotic Hyperosmolar Coma
    d) Secondary Diabetes with Ketoacidosis
    e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
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 Cardiac Implantable Electronic Device (CIED)
13) Iatrogenic Pneumothorax with Venous Catheterization
14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic
15) Procedures
    a) Total Knee Replacement
    b) Hip Replacement

What does 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 additional information on the Medicare HAC/POA program, including billing requirements, please refer to the CMS website provided at cms.hhs.gov/HospitalAcqCond/.

Molina Coding Policies and Payment Policies

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

Reimbursement Guidance and Payment Guidelines

Providers are responsible for the submission of accurate Claims. Molina requires coding of both diagnoses and procedures for all Claims as follows:

- The required coding schemes for diagnoses are the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- For procedures:
    - Professional and outpatient Claims require the Healthcare Common Procedure Coding System, Current Procedural Terminology Level 1 (CPT codes), Level 2 and 3 HCPCS codes.
    - Inpatient hospital Claims require International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) coding schemes.

Furthermore, Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

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

- Manuals and Relative Value Unit (RVU) files published by CMS, including:
    - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a state benefit limit is more stringent/restrictive than a federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a federal MUE or state benefit limit the professional organization standard may be used.
    - In the absence of state guidance, Medicare National Coverage Determinations (NCD).
    - In the absence of state guidance, Medicare Local Coverage Determinations (LCD).
    - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific Claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.

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

Telehealth Claims and Billing

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

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type in accordance with applicable billing guidelines. For guidance, please refer to the following resources:

- Molina's Telemedicine, Telehealth Services and Virtual Visits policy at telehealth.hhs.gov/providers
- HCA Provider billing guides and fee schedules at hca.wa.gov/billers-providerspartners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules
- Center for Connected Health Policy at cchpca.org/all-telehealth-policies/

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 be bundled 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 MUE, which prevents 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, not the date of submission.

Modifiers

Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component.
- Service or procedure has a technical component.
- Service or procedure was performed by more than one (1) physician.
- Unilateral procedure was performed.
- A bilateral procedure was performed.
- Service or procedure was provided more than once.
- Only part of a service was performed.

Consult the AMA CPT and HCPCS code books for a complete listing of modifiers and their appropriate use.

ICD-10-CM/PCS Codes

Molina utilizes the International Classification of Diseases, 10th Revision, Clinical Modification (ICD10-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

POS codes are two (2)-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

The type of bill is a four (4) -digit alphanumeric code that gives three (3) 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 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 CMS-1450 (UB-04) Data Specifications Manual.

Revenue Codes

Revenue codes are four (4)-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (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 NDC number must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, CMS-1450 (UB-04), or its electronic equivalent.
Providers will need to submit Claims with both HCPCS and NDC codes with the exact NDC that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three (3) types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a CMS-maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply, and durable medical equipment codes furnished by physicians and other health care professionals.

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

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

Claim Auditing

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

The Provider acknowledges Molina's right to conduct pre and post-payment billing audits. The Provider shall cooperate with Molina's SIU and audits of Claims and payments by providing access at reasonable times to requested Claims information, the Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. 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 reserves the right, and where unprohibited by regulation, to select a statistically valid random sample or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims Molina paid in error. The estimated proportion, or error rate, may be extrapolated 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 maybe vendor-assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan, and copy all records necessary to determine compliance and accuracy of billing.

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

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 the contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the Claim for service within 95% of all clean claims 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 EFT and 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 MolinaHealthcare.com/providers/wa/medicaid/home.aspx or by contacting the Provider Support Center.

Overpayments and Incorrect Payments Refund Requests

Molina requires network Providers to report to Molina when they have received an overpayment, return the overpayment to Molina within 60 calendar days after the date on which the overpayment was identified, and notify Molina in writing of the reason for the overpayment.

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

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

The Availity Essentials portal has a copy of the overpayment request letter and details. In the Overpayment Application section, Providers can inquire, contest an overpayment with supporting documentation, resolve an overpayment, or check status. This is Molina's preferred method of communication.

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

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling, including the 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 timeframe allowed Molina may offset the overpayment amount(s) against future payments made to the Provider.

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

Claim Disputes/Reconsiderations/Appeals

Information on Claim Disputes/Reconsiderations/Appeals is in the Provider Dispute Resolution and Member Appeals section of this Provider Manual.

Balance Billing

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

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

Fraud, Waste, and Abuse

Failure to report instances of suspected fraud, waste, and abuse is a violation of the law and subject to the penalties provided by law. For additional information, please refer to the Compliance section of this Provider Manual.

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 QI Program, and HEDIS® reporting.

Encounter data must be submitted at least once per month and within your contract's timely filing requirements to meet state and CMS encounter submission thresholds 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 Molina rejects (non-HIPAA compliant) or denies. 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 available to Providers.

When Encounters are filed electronically, each provider should receive a 999 acknowledgment of the transmission and one of the following types of response files:

- Molina will provide one 277CA response file per day for all 837 files submitted; or
- Molina will provide one 835 response file per day for all 837 files submitted.

Integrated Managed Care (IMC) Specialty Behavioral Health Providers

Behavioral Health Supplemental Transactions

As of January 1, 2020, each mental health and/or substance use disorder Provider is required to collect behavioral health supplemental transactions associated with Medicaid Members assigned to Molina. Individual treatment practitioners practicing outside of a licensed behavioral health agency (BHA), including prescribers (i.e., buprenorphine providers), are the only exception to this requirement, and supplemental transaction reporting is not limited to the type or level of service provided. This data is used for state and federal regulatory reporting, as well as supporting the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set (TEDS) and National Outcome Measures (NOMS) reporting requirements.

Providers must submit data per the requirements outlined in the HCA Behavioral Health Supplemental Transaction Data Guide.

The five (5) MCOs have retained Carelon to be the single collection point of this data for all MCO covered services provided in all regions. The only exceptions are Providers of crisis services (who should submit associated supplemental data to the ASO with whom they are directly contracted for those services) and any Provider who is contracted with King County Integrated Care Network (who should submit associated supplemental data directly to KC-ICN. More information on submitting this data through Carelon can be found on their website at BHSD Data Collection | Carelon Behavioral Health of Washington

Evidence/Research-Based Practices

Per Washington state legislation, HCA is required to collect information on which Evidence/Research Based Practices (E/RBP) for children under the age of 18 who are covered under Apple Health Medicaid. Providers must refer to and follow the Evidence-Based Practice Institute's 2023 Reporting Guide for E/RBPs the Service Encounter Reporting Instructions (SERI), and the HCA Billing Guide for Mental Health Services when submitting EBP to Molina through Claims or Encounters. Technical assistance will be provided as needed. Molina transmits this information directly to HCA in a series of reports, per contractual requirements.

Providers are required to participate in approved E/RBPs training as outlined in the Evidence-Based Practice Reporting Guides or as approved by the Evidence-Based Practice Institute. For the Evidence-Based Practices Reporting Guide and additional E/RBP information please refer to ebp-reporting-guides.pdf (wa.gov). Molina will provide additional support or assistance as needed to meet these requirements.

Rosters

The roster template has been vetted and agreed upon by all managed care organizations (MCO) in Washington state. There is an "Instructions" tab for samples and an explanation of each data point included in the roster.

The "RosterTemplatePractitioner" tab must be completed for Molina's system and Provider directory to be updated correctly. The "Behavioral Health" tab is not required by Molina; however, it may be required for other MCOs. The roster template can be found by logging in to the Availity Essentials portal at provider.MolinaHealthcare.com and going to the Forms tab.

Rosters need to be submitted to mhwproviderinfo@molinahealthcare.com for processing. Updates are required, at a minimum, on a quarterly basis.

Late or incorrect roster updates may result in Claim denials.

Helpful hints for completing the IMC rosters:

- Include agency name in the file name (e.g., "ABC BH Agency – All MCO_BH Roster Template….")
- Add/Change/Term (Column A):

    - Comments in column A should reflect the CURRENT updates for your group; remove any comments already submitted to Molina on previous rosters.
    - Changes in this column should be specific (i.e., add, term, license/degree change, location add/term, update Medicaid ID); otherwise, we may not know what has changed or been updated. It is important to note the effective date of the change in the Effective Date/Termination Date column (Column B).
- Practitioner NPI (Column D):
    - Each provider on the roster must have an individual NPI to be loaded in our system.
- Individual ProviderOne ID#/Medicaid ID (Column K):
    - You may submit a provider on the roster even if their ProviderOne number is pending. Please update once available.
- Degree/Title (Column L):
    - Title should be based on licensure or taxonomy, not agency-specific title (e.g., Agency Affiliated Counselor- we cannot determine degree level by that title.)
    - Please be sure to list the appropriate corresponding degree level if it is not obvious by the title, to ensure the correct rates are loaded. Examples are:
        - Psychiatrist (MD/DO)
        - Nurse Practitioner (NP)
        - Physician Assistant (PA)
        - Registered Nurse (RN/ARNP)
        - License Practical Nurse (LPN)
        - Psychologists (PhD/PsyD)
        - Masters-Level Providers (CSW/LCSW/LMFT/LMHC/MA/MBA/MC/MPA/MS/MSN/MSS/MSSA/MSW)
        - Bachelors, AA or Other (BA/BAS/BS/BSW/AA)
        - Peer Counselor (HS)
        - Certified Medical Assistant (CMA)
        - Other (Clinical Staff)
        - Chemical Dependency Professional (CDP) – specify Bachelor's or Masters level if needed based on contract
        - Chemical Dependency Professional Trainee (CDPT) – specify Bachelor's or Master's level if needed based on contract
- Primary Specialty (Column V):
    - You are not limited to the specialties listed on the "Key-Specialties" tab; it is not inclusive of all IMC-related behavioral health specialties.
    - Please only list one specialty in the Primary Specialty column. Additional Specialties can be listed in the Secondary Specialty column (Column AA).
- Primary Specialty Taxonomy (Column W):
    - List the federal taxonomy that is registered with HCA for each provider. We do not need the HCA-specific taxonomies, apart from the Certified Medical Assistants (see below).
    - Certified Medical Assistant Taxonomy: there is no federally recognized taxonomy for this, so please use the HCA taxonomy (101Y99993L).

- Group NPI (Column AH) should be reflective of the group billing NPI, as it will appear in box 33a of claims.
- Group/Practice Name (Column AG) should be the group billing name, as it will appear in box 33 of claims.
- Location (Columns AI-AQ):
    - If a provider practices at multiple locations, please list each location on a separate row and indicate which location is primary.

Obstetric Care Billing for Initial Prenatal Visit

The use of HCPCS code 0500F, along with the appropriate diagnosis code, is required for a Member's initial prenatal visit. The 0500F code must be used along with the appropriate ICD diagnosis codes Z33.1, Z34.00, Z34.80 or Z34.90. The date a Member begins receiving obstetrical care (the date the OB record is initiated) is required for HCA's quality measurements, tracking, and care coordination efforts.

For more information related to obstetric care and delivery billing, see HCA's Physician-related services/health care billing guide at hca.wa.gov/billers-providers-partners/prior-authorizationclaims-and-billing/provider-billing-guides-and-fee-schedules.

13. PROVIDER DISPUTE RESOLUTION AND MEMBER APPEALS

Member Grievances

A Member has a right to file a complaint/grievance at any time about:

- The way you were treated,
- The quality of care or services you received,
- Problems getting care,
- Billing issues.

Members can file a grievance in the following ways:

Mail:

Molina Healthcare
Attention: Member Appeals
PO Box 4004
Bothell, WA 98041-4004

Web: MolinaHealthcare.com
Phone: (800) 869-7165 / TTY 711
Fax: (877) 814-0342
Email: wamemberservices@MolinaHealthcare.com

Member Grievance Timelines

Molina will let the Member know we received their written grievance within two (2) business days. We will resolve the grievance within 45 calendar days and notify the Member how it was resolved.

If a Member has concerns about behavioral health needs, a Behavioral Health Advocate can help them with questions and filing grievances. Visit MolinaHealthcare.com/waombuds to see a list of regional Behavioral Health Advocate representatives.

We will let the Member know we received their grievance within two (2) business days. We will resolve the grievance within 45 calendar days and notify the Member how it was resolved.

Member Appeals

Members can appeal our decision if a service was denied, reduced, or ended early. Here are the steps in the appeal process:

STEP 1: Molina Healthcare Appeal

STEP 2: Administrative Hearing

STEP 3: Independent Review

STEP 4: Health Care Authority (HCA) Board of Appeals Review Judge

Continuation of Services During the Appeal Process

If a Member wants to keep receiving previously approved services while we review the appeal, the appeal must be filed within ten (10) calendar days of the date on the denial letter. If the final decision in the appeal process agrees with our decision, the Member may need to pay for services they received during the appeal process.

STEP 1 – Molina Healthcare Appeal

Members have 60 calendar days after the date of Molina's denial letter to ask for an appeal. The Member or their representative may request an appeal over the phone, in person, or in writing. Additional information to support the appeal may also be submitted over the phone, in writing, or in person. Within five (5) calendar days, we will let the Member know in writing that we received the appeal.

Members can file an appeal in the following ways:

Mail:

Molina Healthcare
Attention: Member Appeals
PO Box 4004
Bothell, WA 98041-4004

Web: MolinaHealthcare.com
Phone: (800) 869-7165 / TTY 711
Fax: (877) 814-0342
Email: wamemberservices@MolinaHealthcare.com

A Member may choose someone, including a lawyer or Provider, to represent them and act on their behalf. However, they must sign a consent form allowing this person to represent them. It is the Member's responsibility to cover any fees or payments to representatives.

Before or during the appeal, the Member or their representative may request copies of all the documents in the appeal file and the guidelines or benefit provisions used to make the decision, free of charge. Molina will send our decision in writing within 14 calendar days unless we notify them we need more time. Our review will not take longer than 28 calendar days.

If the Member needs an expedited decision because the Member's health is at risk, call (800) 869-7165 / TTY 711 for a quick review (called "expedited" review) of the denial.

Members can file an expedited appeal either orally or in writing. Molina will contact the Member with our decision within 72 hours of receiving the request for an expedited review.

If an expedited appeal is requested but Molina decides the Member's health is not at risk, we will follow the regular appeal timeframe. We will send a letter with the decision and a reason for the change within two (2) calendar days of the appeal request.

The expedited timeframe may be extended up to 14 calendar days if additional information to process the appeal is needed and the delay is in your best interest. If Molina extends the timeframe, we will send a letter within two (2) calendar days of the appeal request and a reason for the extension.

STEP 2 – Administrative Hearing

If a Member disagrees with Molina's appeal decision, they can ask for an Administrative Hearing. Members must ask for a hearing within 120 calendar days of the date on the appeal decision letter. A Provider may not ask for a hearing on behalf of a Member. An expedited decision can be requested if the Member's health is at risk.

To request an Administrative Hearing:

Contact the Office of Administrative Hearings (OAH)
Phone: (800) 583-8271
Address: PO Box 42489, Olympia, WA 98504-2489

Members may consult with a lawyer or have another person represent them at the hearing. Members can get help finding a lawyer by checking with the nearest legal services office or calling the NW Justice CLEAR line at (888) 201-1014 or visiting their website at nwjustice.org

If a Member requests an expedited decision, a judge will make a decision within four (4) working days after receiving the request. If the judge decides that the Member's health is not a risk, we will call and send a letter within four (4) working days of the request. The hearing will change to the standard timeframe.

STEP 3 - Independent Review

If a Member does not agree with the decision from the State Administrative Hearing, they can ask for an Independent Review within 21 calendar days of the hearing decision or go directly to Step 4. Call (800) 869-7165 / TTY 711 for help. An expedited decision can be requested if the Member's health is at risk. Any extra information must be given to us within five (5) working days of the request for the Independent Review. We will send the case to an Independent Review Organization (IRO) within three (3) working days. Molina will notify the Member of the decision.

Contact Molina:

Phone: (800) 869-7165 / TTY 711
Fax: (877) 814-0342
Email: wamemberservices@MolinaHealthcare.com

Address: Molina Healthcare, PO Box 4004, Bothell, WA 98041-4004

STEP 4 – Health Care Authority (HCA) Board of Appeals

A Member can ask for a final review of their case by the HCA Board of Appeals Review Judge within 21 calendar days after the IRO decision is mailed. The decision of the HCA Board of Appeals is final.

Phone: (360) 725-0910;
Toll-free: (844) 728-5212
Fax: (360) 507-9018
Address: PO Box 42700, Olympia, WA 98504-2700

Non-Covered Benefit

Exception to Rule: A Member or their Provider may ask Molina to approve a service that is not a covered benefit. For adults, this is called an Exception to Rule (ETR).

- It must be asked for before the Member receives the service.
- To be approved, the Provider must provide us with documentation that establishes that:
    - The Member's condition is different from most people
    - No other covered, less costly service will meet the Member's need.
- The request must meet the rules in the Washington Administrative Code (WAC) 182-501-0160 for approval.

ETR decisions are final and cannot be appealed.

Note: A Member can ask for an appeal at the same time a Provider asks for an Exception to Rule.

Limited Benefit

Limitation Extension: Providers may ask Molina to approve more services above and beyond the regular benefits. An example is more adult physical therapy visits than the 12 visits the benefit allows. This is called a Limitation Extension (LE). To be approved, it must meet the rules in Washington Administrative Code (WAC) 182-501-0169:

- It must be asked for before the Member receives more of the service.
- The Member's condition must show it is improving due to the services already received.
- The Member's condition must show it will likely continue to improve with more services and that it will likely worsen without continued services.

Members can ask for an appeal at the same time as a Provider asks for a Limitation Extension.

Funding for some services is limited by available money: If a Member receives services that are paid for by Medicaid dollars, they have the right to appeal a decision that stops or limits those

services. Some services are paid for with state-only or federal block grant dollars. If the state only or block grant money runs out, we cannot approve the service even if we agree the services are needed. There is no appeal process if a service is ended due to state-only or block grant money running out. We will notify Members if this situation applies to them.

Provider Dispute Resolution Process

The Provider Dispute Resolution process (different from Appeals on behalf of Members) offers recourse for Providers who are dissatisfied with the payment or denial of a Claim from Molina or any of its delegated medical groups/IPAs. Molina follows the Best Practice Recommendation for Extenuating Circumst3ances.

In the event a Provider would like to dispute a Claim, the Provider may make an electronic request via the Availity Essentials portal or fax : (1) within 24 months of Molina's original remittance advice date; (2) within 30 months after final determination by the primary payer. The Provider may not request payment be made any sooner than six (6) months after Molina's receipt of the request. Any request for review of a disputed Claim must be submitted to Molina in accordance with the requirements stated in this section.

Molina requires submission of your dispute through one (1) of two (2) options:

1. **Availity Essentials portal at https://provider.molinahealthcare.com**

To initiate a claim appeal, the provider must search for a claim on the Claims Status page. The provider selects the claim and then clicks "Dispute Claim" to initiate the process.

Next, the provider navigates to the Appeals page where all initiated disputes are listed. To submit their appeal, the provider selects the "actions" icon and selects "Complete Dispute Request." Note the use of the words Appeals and Dispute interchangeably.

A pop-up appears for the provider to complete their request by selecting a request reason, such as Appeal, based on the type of issue. Please include all appropriate documentation with your appeal submission.

New in 2024: Molina has introduced a new feature under the "Complete Dispute Request" function in Availity: A **Claim Reconsideration.** Reconsiderations should be used for basic claim inquiries. Please note that we do not accept attachments for Reconsiderations; if you need to submit documentation (e.g., Medical Records) for your claim to be reviewed, you must submit an Appeal.

The benefits of submitting your dispute request electronically via the Availity Essentials portal at https://provider.molinahelathcare.cominclude:

- The Member, claim number, and Provider information auto-populate in the form.
- Electronically attach chart notes or any other documentation as part of the dispute

- Type additional information you would like to include in the text box regarding your dispute request. Specify why the Provider believes the services should be compensated or adjusted. If the service was denied for no prior authorization/notification, you must include the extenuating circumstances as to why the prior authorization was not obtained.
- In the case of coordination of benefits, including the name and mailing address of any entity that has disclaimed responsibility for payment, including the denied EOB.
- Receive an electronic acknowledgment letter immediately following submission.
- Free of charge, no more postage

2. Fax

The Provider Dispute Resolution Request form must be completed with your request via fax.

- Complete all elements of the Dispute Resolution Request form located at MolinaHealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx. Including supporting medical records and any other required documentation for review of your request. Request forms that are incomplete or missing required information will not be reviewed and will be returned to the Provider without review. Disputes submitted untimely from the original decision will be denied.
- If the dispute is regarding a Claim denied for no prior authorization, you must include the extenuating circumstance as to why authorization was not obtained. Extenuating Circumstances include the inability to know Member had Molina coverage, the inability to anticipate services in advance, inherent components where a service is essential to another, received misinformation from Molina and untimely authorization decision from Molina. In the case of coordination of benefits, include the name and mailing address of any entity that has disclaimed responsibility for payment including the denied EOB. Include proof of due diligence, including dated eligibility confirmation from another payer, such as an eligibility screenshot and/or primary payer's EOB showing denied services or ineligibility of coverage.

Additional information regarding extenuating circumstances can be found under the Best Practice Recommendation for Extenuating Circumstances.

Provider Dispute Fax: (877) 814-0342

Provider Dispute Mailing Address:

Firstsource, Molina Appeals & Disputes WA
PO Box 182273,
Chattanooga, TN 37422

If your Claim was denied by a delegated medical group/IPA, you must make your initial review request through that group. The delegated medical group/IPA addresses for dispute submission are located below. If you have a direct contract with the delegated medical group/IPA, their

decision is final. All other second-level reviews for Providers not directly contracted with the medical group/IPA should be sent to Molina per the process above.

Molina has two (2) levels for the dispute process. Third-level dispute requests will be denied as the dispute process has been exhausted.

Request for provider disputes for medical group/IPA should be submitted to:

Kaiser Foundation Health Plan of the Northwest:
Kaiser Permanente NCA NW Claims Waterpark 1
2500 Havana St.
Aurora, CO 80014

The Provider will be notified of Molina's/delegated medical group IPA decision within 60 days of receipt of the Provider dispute request. Providers are reminded they can NOT bill the Member when a denial for covered services is upheld.

Code Edit Policy Reconsiderations

A Provider can request a reconsideration regarding a code edit policy in situations where the Provider's and Molina's correct coding policy sources conflict or where they may have different interpretations of a common correct coding policy source. The Provider will be notified of Molina's decision in writing within 60 calendar days of the receipt of the Code Edit Reconsideration request unless additional supporting documentation is required.

All requests for Code Edit Policy Reconsiderations must be submitted to Molina in writing and should include the following:

- Explanation of why the Provider does not agree with Molina's current correct coding policy or interpretation. Include the supporting alternative policy information and the source where it can be found.
- Must clearly indicate "Code Edit Policy Reconsideration Request."
- Contact information for your organization's point person, i.e., name, contact number, e-mail address.
- Relevant CPT/HCPCS codes or code combination examples
- Specific claim examples of denied services related to the code edit.
- Must be addressed to the attention of Molina's Provider Services department.

Code Edit Policy Reconsiderations do not apply to eligibility limitations, non-FDA approved services, medical policies, benefit determinations, or contractual disputes. Code Edit Reconsiderations should be faxed to the Provider dispute fax number.

Reporting

Grievance and appeal trends are reported to the Quality Improvement and Health Equity Transformation 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 and Health Equity Transformation Committee for evaluation. If required by the state or CMS, reporting is submitted to the appropriate agency as needed.

14. CREDENTIALING AND RE-CREDENTIALING

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

Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Molina provider services representative.

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

The Credentialing Program has been developed in accordance with state and federal requirements and the standards of the NCQA.

The Credentialing Program is reviewed annually, revised, and updated as needed.

Non-discriminatory Credentialing and Recredentialing

Molina does not make credentialing and re-credentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g., Medicaid) in which the Practitioner specializes. This does not preclude Molina from including in its network Practitioners who meet certain demographic or specialty needs, for example, to the 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
- 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, credentialing, and ongoing participation in the Molina network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentation provided by Molina.

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

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

- **Application**—Practitioners must submit to Molina a complete credentialing application, either from CAQH ProView or other state-mandated practitioner applications. The attestation must be signed within 120 days, and the application must include all required attachments.
- **License, Certification, or Registration – Practitioners must hold a current and valid license, certification,** or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the state where they are located and the state the Member is located.
- **Drug Enforcement Agency (DEA) Certificate** – Practitioners must hold a current, valid, unrestricted DEA certificate. Practitioners must have a DEA in every state where the Practitioner provides care to Molina Members. If a Practitioner has a pending DEA certificate and never had any disciplinary action taken related to their DEA CDS or chooses not to have a DEA CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA CDS certificate to write all prescriptions requiring a DEA number.
- Controlled Dangerous Substances (CDS) Certificate – Practitioners working from ID practice locations must meet CDS requirements in that state.
- **Specialty** – Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education** – Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training** – Practitioners 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 (3) years in length. If the podiatrist has not completed a three (3)-year residency or is not board-certified, the podiatrist must have five (5) years of work history practicing podiatry.
- **Fellowship Training**—Fellowship training is verified when a Practitioner is advertised in the directory in their fellowship specialty. Molina only recognizes fellowship programs accredited by ACGME, AOA, CFPC, and CODA.
- **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 training from an accredited program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five (5) years without any gaps in work history. Molina will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner if the Practitioner is applying to participate as a primary care physician (PCP) or as an urgent care or wound care Practitioner. General Practitioners providing only wound care services do not require five (5) years of work history as a PCP.
- **Nurse Practitioners and Physician Assistants** – In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, the Practitioner providing the supervision and/or oversight must also be contracted and credentialed with Molina.
- **Work History** – Practitioners must supply the most recent five (5) years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the Practitioner must clarify the gap verbally or in writing. The organization will document a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing.
- **Malpractice History** – Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State Sanctions, Restrictions on Licensure, or Limitations on Scope of Practice – Practitioners must disclose a full history of all license/certification/registration actions, including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations,** and non-renewals. Practitioners must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failing to proceed with an application to avoid an adverse action or to preclude an investigation or while under

investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. 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 a Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent.

- **Medicare, Medicaid, and other Sanctions and Exclusions – Practitioners must not be currently sanctioned, excluded, expelled, or suspended from any state or federally funded program,** including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt-Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioner's activities on Molina's behalf. Practitioners maintaining coverage under federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform** – Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of Present Illegal Drug Use** – Practitioners must disclose if they are currently using any illegal drugs/substances.

[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.

- **Criminal Convictions** – Practitioners must disclose if they have ever had any of the following:
    - Criminal convictions, including any convictions, guilty pleas, or adjudicated pretrial diversions for crimes against a person, such as murder, rape, assault, and other similar crimes.
    - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes.
    - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit 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.

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

- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding the loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At re-credentialing, Practitioners must disclose past and present issues regarding the loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioners must have an NPI issued by CMS.

Integrated Managed Care (IMC) Specialty Behavioral Health Providers

Molina credentials IMC Specialty Behavioral Health Agencies at the facility level, as they often employ lower-level providers who cannot be individually credentialed (e.g., peers). The process involves completing a Health Delivery Organization (HDO) application and submitting a complete Provider roster (see more information about Rosters under the Claims and Compensation section of this Provider Manual).

The following credentialing documents must be completed to initiate the process:

- HDO* form

- Completed CMS Ownership Form with recent signature*
    - This form is waived if ALL required NPI billed on a claim form for in-network Providers are registered with HCA.
- Copy of current state license
- Copy of the most recent CMS Survey or accreditation certificate
- Copy of current liability insurance
- Copy of W-9
- Roster of affiliated Practitioners (if applicable) (name, specialty, NPI, scope of service (PCP/Specialist)

*Credentialing documents are in the Credentialing/Contracting section of the Frequently Used Forms section of the Molina website at MolinaHealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx.

Please be sure to register your NPI with HCA at hca.wa.gov/billersproviders-partners/applehealth-medicaid-providers/enroll-provider. This is a federal requirement in order for our plan to enroll Providers. If you have questions regarding this requirement, please direct them to HCA at (800) 562-3022, ext. 16137.

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

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

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

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

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

Molina Healthcare, Inc.
Attention: Credentialing Director
22522 – 29th Drive SE, #L-210
PO Box 4004
Bothell, WA 98041

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, corrections will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

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

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

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

The Practitioner must notify the Credentialing department and request an appointment time to review their file. Allow up to seven (7) calendar days to coordinate schedules. A Medical Director, a 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 the Practitioner may copy 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 the right to be informed of the status of their application by telephone, email, or mail upon request.

Practitioner's rights are published on the Molina website and are included in this Provider Manual. Molina will respond to the request within two (2) working days. Molina will share with the Practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Professional Review Committee (PRC)

Molina designates a PRC to make recommendations regarding credentialing decisions using a peer review process. Molina works with the PRC to ensure that network Practitioners are competent and qualified to provide continuous quality care to Molina members. The PRC reports to the Quality Improvement Committee (QIC.) Molina utilizes information such as, but

not limited to credentialing verifications, QOCs, and member complaints to determine continued participation in Molina's network or if any adverse actions will be taken. Certain PRC decisions may be appealed. To utilize this process, providers should request a fair hearing as outlined below and in Molina's policy. Please contact Molina Provider Relations representatives for additional information about fair hearings.

Notification of Credentialing Decisions

Molina will determine whether to approve or deny a credentialing application no later than 60 days after receiving a complete application from a Practitioner.
A letter is sent to every Practitioner with notification of the Professional Review Committee or Medical Director's decision regarding their participation in the Molina network. This notification
is sent within 15 calendar days of the decision. Copies of the letters are filed in the Practitioner's credentials files.

Recredentialing

Molina credentials every Practitioner at least every 36 months.

Excluded Providers

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

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

Ongoing Monitoring of Sanctions and Exclusions

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

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **The OIG High-Risk List**—Monitor for individuals or facilities that refused to enter a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each State's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Monitor for Medicare exclusions through the CMS MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database**—Molina enrolls all credentialed Practitioners in the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges, and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Practitioners sanctioned by SAM.

Molina also monitors the following for all Practitioner types between the re-credentialing cycles.

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

Effective 07/01/2025, Molina will monitor the timely renewal of healthcare licenses for all Practitioner types. In the event a Practitioner does not renew their state license prior to the expiration date, Molina may take action up to and including payment suspension for dates of service on or after license expiration or termination from applicable Molina provider networks.

Provider Appeal Rights

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

15. DELEGATION

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

1. Utilization Management
2. Credentialing and Recredentialing
3. Claims
4. Complex Case Management
5. CMS Preclusion List monitoring
6. 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 follow 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.

Credentialing functions may be delegated to capitated or non-capitated entities, which meet NCQA criteria for credentialing functions. Call Center, Claims Administration, Care Management, and/or Utilization Management functions are generally only delegated to Vendors or full-risk entities. Non-emergent medical transportation (NEMT) may be delegated to vendors who can meet Call Center, Claims Administration, and/or NEMT requirements.

Note: The Molina Member's ID card will identify which group the Member is assigned to. If Claims Administration and/or UM have been delegated to the group, the ID card will show the delegated group's remit to address and phone number for referrals and prior authorizations.

For a quick reference, the following table reflects the Claims and Referral/Authorization contact information for all medical groups/IPAs currently delegated for Claims payment and/or UM functions for the Medicaid lines of business.

IPA/CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral/Authorization Information
Kaiser Foundation Health Plan of the Northwest	KPNW	IMC-AH (IMC Apple Health) IMC-AHA (IMC Apple Health Adult) IMC-BD (IMC Apple Health Blind Disabled) IMC-PREM (IMC Apple Health w Premium)	Physical Health Services only: Waterpark 1 2500 Havana St Aurora, CO 80014 Behavioral Health Services including Mental Health and Substance use	For Physical Health Services KPNW: Phone: (800) 8132000 Fax: (877) 800-5456 For Behavioral Health
IPA/CAP Group Name	**ID Card Acronym**	**CAP Lines of Business**	**Claims Remit to Address**	**Referral/Authorization Information**
			disorder: Molina Healthcare PO Box 22612 Long Beach, CA 90801	Services including Mental Health and Substance use disorder Molina Healthcare: Phone: (800) 8697185 Fax: (800) 767-7188
Kaiser Foundation Health Plan of the Northwest	KPNW	AHPREM (Apple Health with Premium) AHFAM (Apple Health Family/Pregnancy Medical) AHA (Apple Health Adult) AHBD (Apple Health Blind Disabled)	Physical Health Services and Behavioral Health Services: Waterpark 1 2500 Havana St Aurora, CO 80014	Physical Health Services KPNW: Phone: (800) 8132000 Fax: (877) 800-5456

NOTE: The Member's Molina ID card will identify the group the Member is assigned to by the acronyms listed above. If Claims payment and/or UM has been delegated to the group, the ID card will show the delegated group's remit address and phone number for prior authorizations.

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 reviewed by Molina Delegation

Oversight staff for compliance with performance expectations within the timeline indicated by Molina.

Corrective Action Plans and Revocation of Delegated Activities

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

If you have additional questions related to delegated functions, please contact MHWDelegationOversightDepartment@MolinaHealthcare.com.

Delegation Criteria

Molina is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to subcontracted IPAs, medical groups, or vendors. Molina's DOC or other designated committee must approve all delegation and sub delegation arrangements.

Care Management

To be delegated for care management functions, medical groups, IPAs, and/or vendors must:

- Be certified by NCQA for case management and disease management programs.
- Have current case management and disease management program descriptions in place. Have a screening process in place to review all medical group, IPA, and/or vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every 30 days after hire.
- Pass a care management pre-assessment audit based on NCQA, federal and state requirements, and Molina business needs.
- Correct deficiencies within mutually agreed-upon timeframes when issues of noncompliance are identified by Molina.
- Agree to Molina's contract terms and conditions for care management delegates.
- Submit timely and complete care management delegation reports to the applicable Molina contact, as detailed in the Delegated Services Agreement.
- Comply with all applicable federal and state laws.

Note: Molina does not allow care management delegates to further sub-delegate care management activities.

A medical group, IPA, or vendor may request care management from Molina through Molina's Delegation Oversight Manager or through the medical group, IPA, or vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review

and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the DOC for review and approval. The final decision to delegate care management responsibilities is based on the medical group, IPA, or vendor's ability to meet Molina, state, and federal requirements for delegation.

Organizations delegated for care management may have additional reports required to assist Molina in fulfilling its oversight responsibilities.

Claims Administration

To be delegated for Claims Administration, medical groups, IPAs, and/or vendors must do the following:

- Have a capitation contract with Molina and comply with the financial reserve's contract requirements.
- Be delegated for UM by Molina.
- Protect the confidentiality of all PHI as required by law.
- Have processes in place to identify and investigate potential fraud, waste, and abuse.
- Have a Claims Administration delegation pre-assessment completed by Molina to determine compliance with all applicable state and federal regulatory requirements for Claims Administration.
- Correct deficiencies within the timeframes identified in the correction action plan (CAP) when Molina identifies issues of non-compliance.
- Must have an automated system capable of accepting electronic claims in an ICD 10 compliant format.
- Must have an automated system capable of providing Molina with the Encounter Data required by the state in a format readable by Molina.
- Establish a screening process to review all medical group, IPA, and/or vendor employees and staff of all levels against OIG and SAM lists prior to hire dates and at least every 30 days.
- Agree to Molina's contract terms and conditions for Claims Delegates.
- Submit timely and complete Claims Administration delegation reports as detailed in the
- Within 45 days of the end of the month in which care was rendered, provide Molina with the Encounter Data required by the state in a format compliant with HIPAA requirements. • Provide additional information as necessary to load Encounter Data within 30 days of Molina's request.
- Comply with the standard Transactions and Code Sets requirements for accepting and sending electronic health care Claims information and remittance advice statements using the formats required by HIPAA.
- Comply with all applicable federal and state laws.
- When using Molina's contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Molina's Claims Administration policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims.

A medical group, IPA, or vendor may request a Claims Administration delegation from Molina through Molina's Delegation Oversight Manager or through the medical group, IPA, or vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the DOC for review and approval. The final decision to delegate Claims Administration responsibilities is based on the medical group, IPA, or vendor's ability to meet Molina, state, and federal requirements for delegation.

Organizations delegated for Claims and/or Encounters may have additional reports required to assist Molina in fulfilling its oversight responsibilities.

Credentialing

Credentialing functions may be delegated to entities that meet NCQA criteria for credentialing functions. To be delegated for credentialing functions, medical groups, IPAs, and/or vendors must:

- Pass Molina's credentialing pre-assessment.
- Have a multidisciplinary Credentialing Committee that is responsible for reviewing and approving or denying/terminating practitioners included in the delegation.
- Establish an Ongoing Monitoring process that screens all practitioners included in delegation against OIG, SAM, Washington State Department of Health, News Releases, and published state Medicaid exclusion and termination lists at least every 30 calendar days.
- Have a process for monitoring adverse events at least every six (6) months.
- Establish a screening process to review all medical group, IPA, and/or vendor employees and staff of all levels against OIG and SAM lists prior to hire dates and at least every 30 calendar days after hire.
- Correct deficiencies within mutually agreed-upon timeframes when issues of noncompliance are identified by Molina.
- Agree to Molina's contract terms and conditions for credentialing delegates.
- Submit timely and complete Credentialing delegation reports using the current version of the Standardized Delegate Roster Template which is also detailed in the Delegated Services Agreement to the applicable Molina contract.
- Comply with all applicable federal and state laws.
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members.
- Enroll all practitioner NPIs into Washington State ProviderOne and revalidate once every five (5) years.
- Submit a copy of the current NCQA certification or accreditation document.

If the medical group, IPA, or vendor sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions or demonstrate an ability to meet all Health Plan, NCQA, and state and federal requirements identified above. A written

request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and at least annually thereafter. Evaluation should include a review of Credentialing policies and procedures, Credentialing and credentialing files, Credentialing Committee Minutes, ongoing monitoring documentation, and a process to implement corrective action if issues of non-compliance are identified.

A medical group, IPA, or vendor may request a Credentialing delegation from Molina through Molina's Delegation Oversight Manager or through the medical group, IPA, or vendor's Contract Manager. Molina will ask the potential delegate to submit a Credentialing Pre-assessment survey, ongoing monitoring documentation, policies, and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the DOC for review and approval. The final decision to delegate Credentialing responsibilities is based on the medical group, IPA, or vendor's ability to meet Molina, state, and federal requirements for delegation.

Organizations delegated for Credentialing may have additional reports required to assist Molina in fulfilling its oversight responsibilities.

Utilization Management (UM)

To be delegated for UM functions, medical groups, IPAs, and/or vendors must:

- Have a UM program that has been operational at least one (1) year prior to the delegation and includes an annual UM Program evaluation and annual Inter-Rater Reliability audits of all levels of UM staff.
- Pass Molina's UM pre-assessment, which is based on NCQA, state and federal UM standards, and Molina policies and procedures.
- Correct deficiencies within mutually agreed-upon timeframes when issues of noncompliance are identified by Molina.
- Ensure that only licensed physicians/dentists/pharmacists make medical necessity denial decisions.
- Ensure that only appropriate levels of clinical staff make medical necessity approval decisions.
- Establish a screening process to review all medical group, IPA, and/or vendor employees and staff of all levels against OIG and SAM lists prior to hire dates and at least every 30 calendar days after hire.
- Agree to Molina's contract terms and conditions for UM delegates.
- Submit timely and complete UM delegation reports as detailed in the Delegated Services Agreement to the applicable Molina contact.
- Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA.
- Comply with all applicable federal and state laws.

Molina does not allow UM delegates to further sub-delegate UM activities.

A medical group, IPA, or vendor may request a UM delegation from Molina through Molina's Delegation Oversight Manager or through the medical group, IPA, or vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the DOC for review and approval. The final decision to delegate UM responsibilities is based on the medical group, IPA, or vendor's ability to meet Molina, state, and federal requirements for delegation.

Organizations delegated for UM may have additional reports required to assist Molina in fulfilling its oversight responsibilities.

Quality Improvement/Preventive Health Activities

Molina does not delegate Quality Improvement activities to Provider Organizations. Molina will include all network Providers, including those in medical groups, IPAs or vendors who are delegated for other functions (Claims, Credentialing, UM, etc.) in its Quality Improvement Program activities and preventive health activities. Molina encourages all contracted Provider organizations to conduct activities to improve the quality of care and service provided by their organization. Molina would appreciate receiving copies of studies conducted or data analyzed as part of the medical group, IPA, or vendor's Quality Improvement Program.

Capitation Models

Molina employs a variety of capitation reimbursement models; only organizations or individuals with a significant number of Members to spread the financial risk are approved for capitation contracts.

Primary Care Capitation: An individual PCP or a group of PCPs receive a monthly prepaid amount from Molina as compensation for a contractually defined set of services, which are designated as capitated by Molina.

Full Risk/Global Capitation: IPA or PHO receives a monthly prepaid amount from Molina as compensation for a contractually defined set of services, which are designated as capitated by Molina. These services are typically global in nature (i.e., these groups have assumed financial responsibility for all covered health care services unless specifically carved out by Molina). Financial responsibility for all services (including carve-outs) is defined in the financial responsibility matrix attached to the full risk/global capitation agreement.

Financial Viability of Capitated Organizations

Molina is obligated to monitor the financial status of the groups to whom it has given financial risk. This is a contractual and business responsibility. We use all reasonable methods to prevent placing an organization at risk for more than they can manage. We work to ensure there is little risk to any Providers who would look to the organization for payment of Claims. Prior to the initial contracting under a capitation model with an organization, Molina assesses the

organization's financial condition by reviewing the two (2) most recent years' audited financial statements and year-to-date unaudited financial statements for the current year.

Physician Incentive Plan (PIP)

Every year, Molina is required to submit a report to HCA disclosing incentive terms for all Provider contracts. For Providers/Provider groups with substantial financial risk (any organization that could be adversely or positively affected financially by the referral volume of its Members), Molina is required to disclose additional documentation.

Organizations with substantial financial risk must provide information to Molina including:

- Mode of payments to Providers and any payment plans considered to be PIPs.
- Evidence of stop-loss protection
- Evidence of annual Member satisfaction surveys

Reporting Requirements of Organizations

Once contracted, Molina expects all organizations, identified as bearing substantial financial risk on the PIP, to submit the following documents to Molina:

Complete quarterly financial statements including:

- Balance Sheet
- Income Statement
- Statement of Cash Flows
- Audited annual financial statements.

Organizations delegated for Claims may have additional reports required to assist Molina in fulfilling its financial oversight responsibilities.

Capitation Operations

Joint Operations Committee Meetings: Molina is available to meet as needed to address operational or contractual issues. On a quarterly basis, Molina tries to meet with each of its organizations that operate under a capitation model. The purpose of the meetings is to:

- Identify any operational difficulties between the organization and Molina and determine plans for a remedy.
- Educate one another on changes to either the organization or Molina.
- Provide an opportunity for staff to meet their counterparts to facilitate more productive interactions.

The Provider Relations Representative facilitates the meetings, which include any other Molina staff members pertinent to the issues at hand.

Funds Flow Document: Because the contract is a lengthy and somewhat complicated document, Molina works with the capitated organization to write a Funds Flow document outlining:

- Payment rates
- Mode of payment
- Division of financial responsibility
- Any special payment arrangements

The purpose of this document is to provide all involved staff at the organization and Molina with a guide for adhering to the terms of the contract.

Encounter Reporting

Each capitated organization delegated for Claims payment is required to submit encounter data for all adjudicated Claims. The data is used for many purposes, such as reporting to the Medicaid Statistical Information System (MSIS), Apple Health rate setting and risk adjustment, HCA's hospital rate setting, the quality improvement program, and HEDIS® reporting.

16. PHARMACY

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our Members with high-quality, cost-effective drug therapy. Molina works with our Providers to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter drugs.

Pharmacy Network

Members must use their Molina Member ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting MolinaHealthcare.com or calling Molina at (855) 322-4082.

Drug Formulary

Molina uses a list of drugs, devices, and supplies from the HCA that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can get from a pharmacy. Some medications require prior authorization (PA) or have limitations on age, dosage, and/or quantities. For a complete list of covered medications please visit MolinaHealthcare.com.

This document describes procedures for obtaining these medications, which are also available on the Molina website at MolinaHealthcare.com.

Formulary Medications

Formulary medications with PA may require the use of first-line medications before they are approved. Information on procedures to obtain these medications is described within this document and is also available on the Molina website at MolinaHealthcare.com

Quantity Limitations

In some cases, Members may only be able to receive certain quantities of medication. Information on specific limits can be found in the formulary document. 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.

Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form which is available on the Molina website at MolinaHealthcare.com. Clinical evidence must be provided and is considered when evaluating the request to determine medical necessity. The use of manufacturer samples of non-formulary or "Prior Authorization Required" medications does not override Formulary requirements.

Generic Substitution

Generic drugs should be dispensed when preferred. If the use of a particular brand name nonpreferred drug becomes medically necessary as determined by the Provider, PA must be obtained through the standard PA process.

New-to-Market Drugs

Newly approved drug products are generally not added to the formulary immediately; this process may take up to six months. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

There are some medications that are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes may not be part of the benefit. Specific exclusions can be found in the formulary document at MolinaHealthcare.com.

Submitting a Prior Authorization Request

Molina's vendor, CVS Caremark will only process completed PA request forms; the following information MUST be included for the request form to be considered complete.

- Member first name, last name, date of birth, and identification number
- Prescriber first name, last name, NPI, phone number, and fax number
- Drug name, strength, quantity, and directions of use
- Diagnosis

Electronic prior authorization (ePA): SureScripts® and CoverMyMeds

Clinical decisions are based on the information included in the PA request. Clinical notes are recommended. If clinical information and/or medical justification are missing, Molina will either respond via the electronic prior authorization (ePA) portal, fax, or call your office to request that clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

CVS Caremark utilizes ePA portal submissions through the SureScripts® and CoverMyMeds® platforms that are integrated into physician office electronic health record (EHR) systems. The ePA portal automates the prior authorization process, making it a quick and simple way to complete prior authorization requests. The ePA portal process is HIPAA compliant and can enable faster coverage determinations. For select drugs and plans, CoverMyMeds® may issue immediate approval of your request and update your patient's prior authorization record to allow immediate claim adjudication.

Fax a completed Medication PA Request form to Molina at (800) 869-7791. A blank Medication PA Request Form may be obtained by accessing MolinaHealthcare.com or by calling (855) 322-4082.

Member and Provider "Patient Safety Notifications"

Molina has a process for notifying Members and Providers regarding a variety of safety issues, including voluntary recalls, FDA-required recalls, and drug withdrawals for patient safety reasons. This is also a requirement for 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 may be covered through the medical benefit using the Healthcare Common Procedure Coding System (HCPCS) via electronic medical Claim submission.

During the utilization management review process, Molina 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's specific benefit plan coverage prior to determining benefit processing.

Molina may conduct a 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.

If it is determined to be a Pharmacy benefit, Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes, and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations representative with any further questions about the program.

Molina clinical services complete utilization management for certain Healthcare Administered Drugs. Any drugs on the prior authorization list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which is later assigned a new HCPCS code, will still require prior authorization for such drug even after it has been assigned a new HCPCS code.

Prescription Drug Monitoring Program

Beginning October 1, 2021, all states will require Medicaid Providers to check the prescription drug monitoring program (PMP) before prescribing and shortly after dispensing a controlled substance (Schedule II through Schedule V) to a Medicaid client.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization are priorities. Molina requires Providers to adhere to its drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioids and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on Molina's Provider website. Providers may access additional Opioid-safety and Substance Use Disorder (SUD) resources at MolinaHealthcare.com under the Health Resource tab. Please reference the medication formulary for more information on Molina's Pain Safety Initiatives.

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