MemorialCare
Select Health Plan

Congratulations on starting the Credentialing process with MemorialCare Select Health Plan!

As part of our on-boarding new providers are required to complete regulatory training and attestations. Attached you will find several documents for your review & acknowledgment.

Please ensure timely completion and submission of each required attestation to MCSelectProvider@memorialcare.org

1. **L.A. Care New Provider Orientation Handbook**
   - o L.A. Care Health Plan - New Provider Training
   - o Critical Incident Training
   - o 2024 Provider Model of Care Training
2. **L.A. Care Training Attestation** - **L.A. Care requires the Provider to date & sign and return to MCSHP. pg. 94**
3. **L.A. Care Health Plan's New Provider Orientation Training Sign-in Sheet. L.A. Care requires all fields to be complete, dated & signed. pg. 95**
4. **Health Net Provider Training** - Educational training materials can be found on Health Net's website: https://www.healthnet.com/content/healthnet/en_us/providers/support/provider-welcome.html **pg. 96**
   - o **Initial #2** on the Health Net attestation, acknowledging you have received HN's new on-line provider training using the link above.
   - o **Initial # 3** attesting that you understand responsibilities related to HN's Medi-Cal managed care program.
5. **Molina New Provider Orientation/Training**
6. **Molina Training Attestation pg.249**
   - o Admin signature required.
7. **MemorialCare Select New Provider Orientation Packet - Informational only**
   - o MCSHP Contact information
   - o MCSHP Website & Provider Portal

Feel free to contact us with questions and thank you for your partnership!

Thank you,
MemorialCare Select Provider Services
Phone: 855-367-7747, Option 4
Fax: 657-241-3960

E-mail: MCSelectProvider@memorialcare.org
Website: www.memorialcareselecthealthplan.org

Accreditation of Medi-Cal, Healthy Kids and Healthy Families Program.

The New Provider Orientation Handbook

L.A. Care HEALTH PLAN®

Revised: 10/14/15

LA1456 10/15

Dear L.A. Care Contracted Provider,

L.A. Care Health Plan (L.A. Care) has created this provider orientation handbook to ensure that your L.A. Care contracted Participating Provider Group (PPG) or Management Services Organization (MSO) has the necessary tools to train you, the Primary Care Physicians and/or Specialists, on the Medi-Cal Managed Care program and L.A. Care's policies and procedures.

According to L.A. Care's contract with the State of California's Department of Health Care Services, new contracted providers MUST be trained within 10 business days of active status.

The information provided will allow you and your staff to gain a broad understanding of L.A. Care's mission, the importance of positive customer service experiences, member benefits, and member rights and responsibilities. If you would like more information, please reference the L.A. Care Provider Manual by visiting **www.lacare.org**.

Additionally, if you need clarification on any of the information provided, please contact your PPG or MSO for further guidance.

Welcome to the L.A. Care Health Plan Network!

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L.A. Care's History

Established in 1997, L.A. Care is an independent local public agency created by the state of California to provide health coverage to low-income Los Angeles County residents. L.A. Care is the nation's largest publicly operated health plan. Serving more than 1.8 million members, our mission is to ensure our members get the right care at the right place at the right time. For more history and information on L.A. Care, please visit **www.lacare.org**.

L.A. Care's Delegated Model

L.A. Care delegates certain authorization and claims processing to some of its contracted Participating Provider Groups (PPGs) and Management Services Organizations (MSOs). Delegation is when an entity gives another entity the authority to carry out a function that it would otherwise perform, such as operating within the parameters agreed upon between the health plan and PPG/MSO.

The National Committee on Quality Assurance (NCQA) holds L.A. Care to the following requirements:

- Delegation Agreement - A mutual agreement between L.A. Care and its PPG/MSO outlining specific delegated functions that meet NCQA standards.
- Oversight and Monitoring – L.A. Care must oversee the delegates to ensure that the delegate is properly performing all delegated functions.

For more information on NQCA standards and functions, please visit their website at **http://www.ncqa.org/AboutNCQA.aspx**.

Medi-Cal Managed Care provides high quality, accessible, and cost-effective health care through managed care delivery systems. Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care which emphasize primary and preventive care. Managed care plans like L.A. Care, have been proven to be a cost-effective use of health care resources that improve health care access and assure quality of care.

In order to determine who is responsible for paying a claim, please contact the members assigned PPG/MSO or reference your PPG/MSO contract for more information.

Timely Filing Deadline

L.A. Care cannot impose a timeframe for receipt of an 'initial claim' submission less than 90 days for contracted providers or 180 days for non-contracted providers after the date of service for timely filing for a new claim.

Billing

All paper claims must be submitted on CMS 1500 form for professional services and UB-04 form for facility services. L.A. Care accepts EDI submissions, please reference **http://www.lacare.org/providers/provider-resources/provider-forms**.

Claims Adjudication

Each claim is subject to a comprehensive series of quality checks called "edits" and "audits." Quality checks verify and validate all claim information to determine if the claim should be paid, denied or suspended for manual review. Edit and audit checks include verification of:

- Data validity
- Procedure and diagnosis compatibility
- Provider eligibility on date of service
- Recipient eligibility on date of service
- Medicare or other insurance coverage
- Claim duplication
- Authorization requirements

Provider Portal Claims Verification

- The L.A. Care Provider Portal is the preferred method for contracted providers to check claims status. Please see information on how to access the L.A. Care Provider Portal in the Provider Portal section of this handbook.
- The secondary method to check claims status is by calling 1-866-LA-CARE6.

Balanced Billing

Balance billing L.A. Care members is prohibited by law. Contracted providers cannot collect reimbursement from a L.A. Care member or persons acting on behalf of a member for any services provided, except to collect any authorized share of cost.

Provider Disputes

When the claim is the responsibility of the PPG/MSO, a provider dispute can be filed in writing with the PPG/MSO. Contact the PPG/MSO for more information on how to file a claims dispute. If the provider is dissatisfied with the resolution of the initial dispute filed with the PPG/MSO, a second level dispute may be filed with L.A. Care's Claims Provider Disputes unit. A copy of the PPG/MSO denial or Notice of Decision letter must fully describe the dispute and the PPGs/MSOs decision. The second level dispute must include a description of timelines as well as information to support the description of the dispute along with the claim.

Provider disputes must be submitted to:
L.A. Care Health Plan
Attention: Provider Disputes
P.O. Box 811610
Los Angeles, CA 90081

Authorizations

In order to determine who is responsible for authorization of services, please contact the members' assigned PPG/MSO or reference your contract with the PPG/MSO for more information.

Professional authorizations and payment of claims for those services are usually the responsibility of the PPG. For all other services, PPGs/MSOs and L.A. Care have a contractual document that defines which entity is responsible for a service (e.g., Division of Financial Responsibility and a Delegation Agreement). For additional information on what services are paid for by the PPG or L.A. Care, please call your PPG/MSO.

You can access the *Delegation Matrix* tool to identify which PPG is at risk for authorizing services by visiting **http://www.lacare.org/sites/default/files/Provider%20Authorization%20and%20Billing%20Guidance%2006%2017%2015.pdf**

A copy of L.A. Care's Authorization Request Form is available at: **http://www.lacare.org/sites/default/files/PL0022c_Updated_Auth_Req_Form_10%2001%202015_FINAL.pdf**

Services That Do Not Require Prior Authorization

- Emergency Services, whether in or out of L.A. County but within the continental USA (except for care provided outside of the United States which is subject to retrospective review)
- Emergency Care provided in Canada or Mexico is covered
- Urgent care, whether in or out of network
- Mental health care and substance use treatment
- Routine Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams
  - This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
- Basic prenatal care – a woman can go directly to any network provider for basic pre-natal care
- Family planning services, including: counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases, includes: testing, counseling, treatment and prevention
- Emergency medical transportation

Services That May Require Prior Authorization

Note: As the Prior Authorization process may vary between PPGs/MSOs, verify with your contracted PPG/MSO that these services are correct.

- Non-emergency out of area care (outside of L.A. County)
- Out of network care, services not provided by a contracted network doctor
- Inpatient admissions, post-stabilization/non-emergency/elective
- Inpatient admission to skilled nursing facility or nursing home
- Outpatient hospital services/surgery
- Outpatient, non-hospital , such as surgeries or sleep studies
- Outpatient diagnostic services, minimally invasive or invasive such as CT Scans, MRIs, colonoscopy, endoscopy, flexible sigmoidoscopy, and cardiac catheterization

- Durable Medical Equipment, standard or customized; rented or purchased
- Medical Supplies
- Prosthetics and Orthotics
- Home Health Care, including: nurse aide, therapies, and social worker
- Hospice
- Transportation (excluding emergency medical transportation)
- Experimental or Investigation Services
- Cancer Clinical Trials

Hospital and Ancillary Provider Network

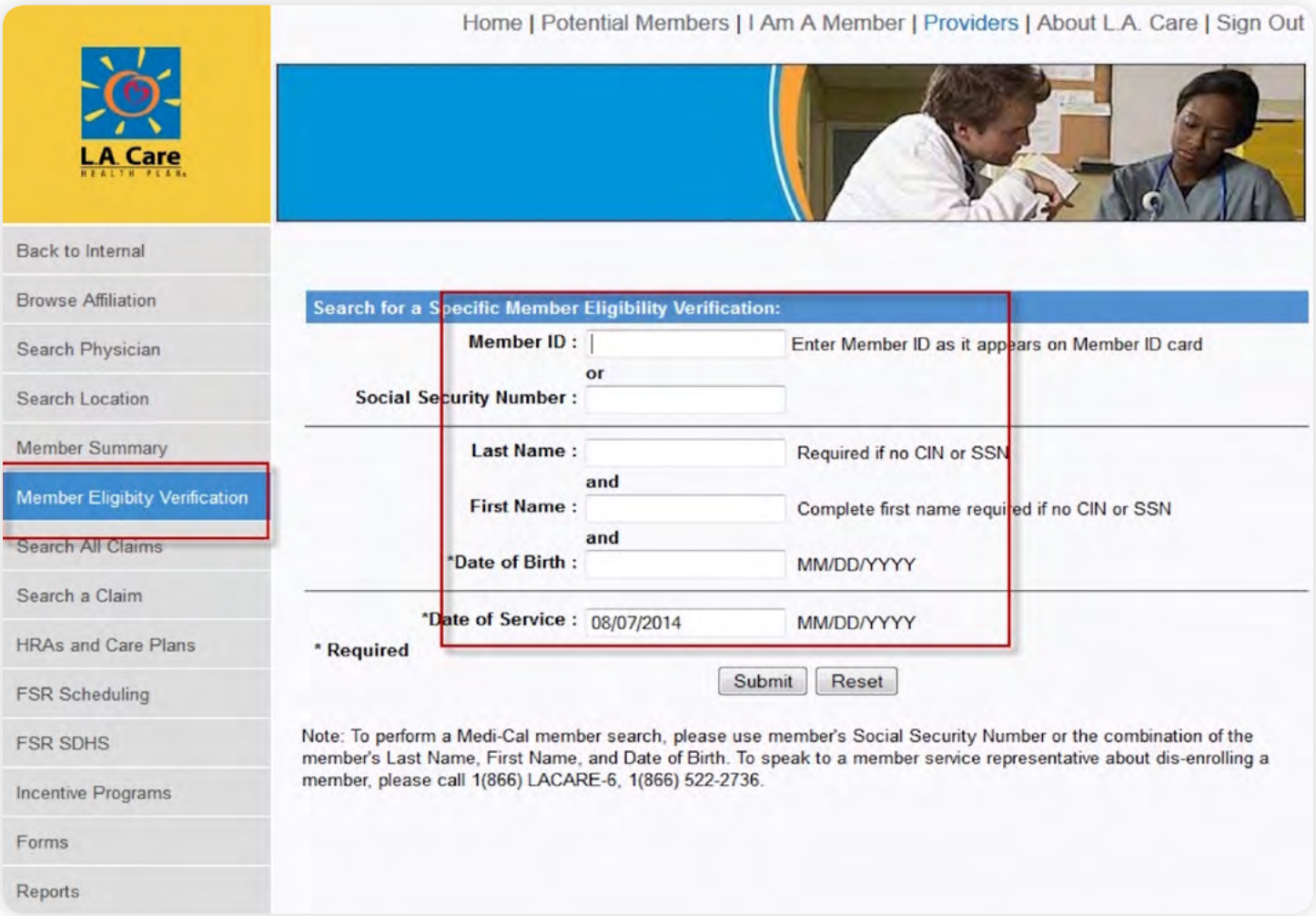
L.A. Care maintains a network of contracted hospitals and ancillary providers. Please contact your PPG/MSO for the most recent list to be utilized for services provided to L.A. Care Direct members.

Checking Member Eligibility

A. Log on to the Provider Portal then select "Member Eligibility Verification."

B. Please fill out all fields with as much information as possible to get the best results. Click "submit" when finished. See Figure 1.

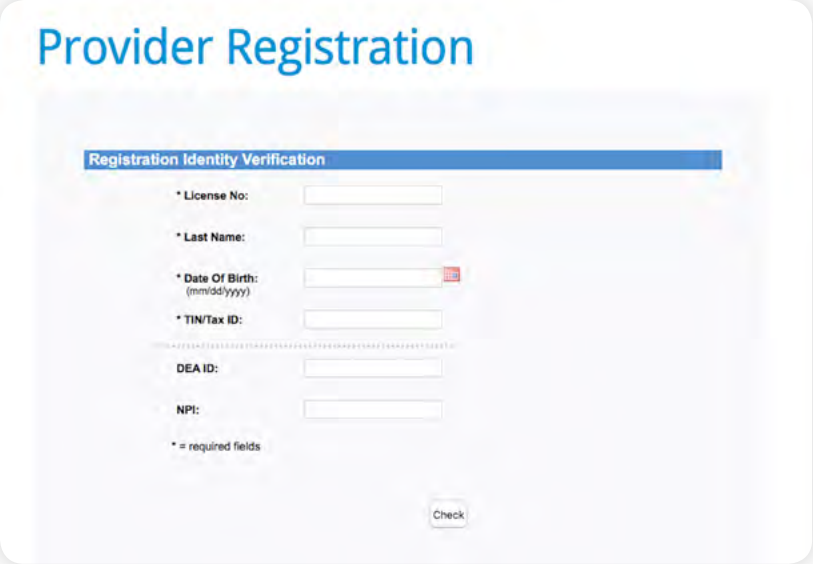
Figure 1.



Provider Portal: Registering a New Provider
All contracted physicians and specialist may self-register at
http://www.lacare.org/providers/provider-sign-in/provider-registration.

All information marked with an asterisk is required in order for your request to be processed. See Figure 2.

Figure 2.



All other medical and administrative staff have to submit a request for registration for the Provider Portal. This request can be submitted via email to **providerrelations@lacare.org** or by phone at 1-213-694-1250 x 4719. The required information that needs to be specified is listed below:

- Name of organization (as listed in the contract)
- Organization address
- Full name of person(s) that need access
- Job title
- Phone number
- Email address
- Purpose/reason why access is needed

Please note all Provider Portal registration requests will be processed within 3 - 5 business days.

Once you receive access to the Provider Portal you will be notified via email to confirm your registration. You will have 24 hours to activate your account with the link provided to you by email. If you do not activate your account within the 24-hour period you will have to contact the Provider Relations department at **PPO@lacare.org** or by phone at 1-213-694-1250 x5200 to receive a new activation email for your account.

Seniors and Persons with Disabilities

Under federal and state law, medical care providers must provide individuals with disabilities:

- Full and equal access to their health care services and facilities
- Reasonable modifications to policies, practices, and procedures when necessary to make health care services accessible and,
- Effective communication, including auxiliary aids and services, such as the provision of sign language interpreters or written materials in alternative formats.

Physical Access

Providers must make their facilities, as well as their medical equipment and exam rooms accessible. The law requires the development and maintenance of accessible paths of travel to elevators, ramps, doors that open easily, reachable light switches, accessible bathrooms, accessible parking and signage that can assist individuals who are blind or have low vision.

Additionally, health care providers must provide accessible equipment, such as exam tables, diagnostic equipment and the use of a lift or trained staff who can ensure equal access to medical testing.

Reasonable Modifications

The Americans with Disabilities Act (ADA) provides protection from discrimination for people with all types of disabilities, including people with physical, cognitive, communication and mental health disabilities. Health care providers must make reasonable modifications in policies, practices and procedures when necessary to avoid discrimination on the basis of disability, unless the provider can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity.

Examples of reasonable modifications health care providers may need to make for individuals with disabilities are:

- Spend additional time explaining individualized member care plans to ensure understanding
- Scheduling an appointment to accommodate a member with an anxiety disorder who has difficulty waiting in a crowded waiting room
- Allowing members to be accompanied by service dogs

Note: A health care provider cannot require individuals who are visually impaired or hard of hearing to bring someone with them to interpret or facilitate communication. Health care providers cannot charge members for providing any form of interpreter services.

Procedures for Providing Accommodations

Health care providers must:

- Ensure that individuals are informed of their right to request accommodations
- Provide individuals with information about the process for requesting accommodations
- Provide individuals with information about filing complaints about accommodations with L.A. Care if the provider is in the L.A. Care network, and filing complaints with other entities that oversee disability access laws in the health care context.

Health Assessments and Provider Toolkits

Initial Health Assessments

Primary Care Providers (PCP) are responsible for conducting a health assessment screening. All new members must have an initial health assessment (IHA) within:

- Medi-Cal members - 120 calendar days from the date of enrollment with L.A. Care. L.A. Care does not mandate utilization of a standardized form for the IHA. L.A Care does require the documentation of specific elements of the assessment. L.A. Care does provide samples of Well Child Assessment forms. A full description of the IHA process is available in the L.A. Care Provider Manual. Copies of the assessment forms are available at: **http://www.lacare.org/providers/provider-resources/provider-faqs/well-child-assessment-forms**.

Staying Healthy Assessments

For Medi-Cal enrollees, L.A. Care requires the completion of the Staying Healthy Assessments to be administered during the IHA and periodically thereafter as the patient enters a new age category. Forms are located at: **http://www.lacare.org/providers/provider-resources/staying-healthy-forms**.

Provider Toolkits

L.A Care maintains accessible toolkits and resources to assist providers in managing the care of our members. Currently toolkits include:

- Appropriate Use of Antibiotics
- Asthma
- Cardiovascular Care
- Childhood and Adolescent Wellness Flyers
- Chlamydia
- COPD
- Diabetes and Cardiovascular Care
- Obesity Toolkit for Adult and Children
- Pre/Post Bariatric Surgery Toolkit
- Perinatal Care
- Tobacco Control and Cessation
- Better Communication, Better Care: A Provider Toolkit for Serving Diverse Populations
- Behavior Health Provider Toolkit
- Behavioral Health Toolkit for PCPs
- Depression Provider Toolkit

The medical and mental health toolkits are available at **http://www.lacare.org/providers/provider-resources/provider-tool-kits**.

The CHDP program provides health assessments for the early detection and prevention of disease and disabilities for low-income children and youth.

CHDP health assessments screenings should consist of the following:

- health history
- physical examination
- developmental assessment
- nutritional assessment
- dental assessment
- vision and hearing tests
- a tuberculin test
- laboratory tests
- immunizations
- health education/anticipatory guidance
- referrals for any needed diagnosis and treatment

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

PCPs are required to follow-up with the components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) are a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need and diagnosis; treatment services are provided. EPSDT services include all services covered by Medi-Cal. A beneficiary under the age of 21 may receive additional medically necessary services.

EPSDT Screening Services

Screening services provided at intervals that meet standards of medical and dental practice, and at such other medically necessary intervals to determine the existence of physical or mental illnesses or conditions. Screening services must at a minimum include:

- a comprehensive health and developmental history (including assessment of both physical and mental health development)
- a comprehensive physical exam
- appropriate immunizations
- laboratory tests (including blood lead level taking into account age and risk factors)
- health education (including anticipatory guidance)

EPSDT Diagnostic Services

EPSDT covers medically necessary diagnostic services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis without delay.

ESPDT Treatment Services

Mental Health and Substance Use Services:

- Treatment for mental health and substance use issues and conditions is available under a number of Medi-Cal service categories, including hospital and clinic services, physician services, and services provided by a licensed professional such as a psychologist.

Medically Necessary Personal Care Services

- Are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility, or institution for mental disease, that are:

  (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State), otherwise authorized for the individual in accordance with a service plan approved by the State

  (B) provided by an individual who is qualified to provide such services and is not a member of the individual's family

  (C) furnished in a home or in another location

Oral Health and Dental Services:

- Dental care needed for relief of pain, infection and maintenance of dental health (provided as early an age as necessary).
- Emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures.
- Medi-Cal Dental Care and Treatment Services are a carved out benefit for Medi-Cal members through the Medi-Cal Denti-Cal Program. Primary Care Providers are expected to perform dental screenings on all Medi-Cal members as part of the IHA, periodic, and other preventive health care visits and provide referrals to the Medi-Cal Denti-Cal Program for treatment. For children, Denti-Cal uses the periodicity schedule recommended by American Academy of Pediatric Dentistry (AAPD). Also some Dental benefits for adults 21 and older have been recently restored. To find a dentist, Medi-Cal members should be advised to call Denti-Cal at 1-800-322-6384 or visit **http://www.denti-cal.ca.gov**.

Vision and Hearing Services

- EPSDT requires that vision services be provided at intervals that meet reasonable standards as determined in consultation with medical experts, and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- At a minimum, vision services must include diagnosis and treatment for defects in vision, including eyeglasses.
- Glasses to replace those that are lost, broken, or stolen also must be covered.
- Medi-Cal vision benefits are covered by L.A. Care.
- L.A. Care has contracted with Vision Service Plan (VSP) to coordinate Medi-Cal vision care and lenses.
- To find out more about eye exams or vision care coverage for Medi-Cal members, call VSP at 1-800-877-7195 [TTY/TDD 1-800-428-4833].
- To find out more about eye exams or vision care coverage, you can also call L.A. Care Member Services at the toll free number 1-888-839-9909 [TTY/TDD 1-866-522-2731].

- EPSDT requires that hearing services be provided at intervals that meet reasonable standards as determined in consultation with medical experts, and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

Vaccines for Children (VFC)

The Vaccines for Children Program, established by an act of Congress in 1993, helps families by providing free vaccines to doctors who serve eligible children 0 through 18 years of age. The VFC program is administered at the national level by the United States Centers for Disease Control and Prevention (CDC) through the National Center for Immunization and Respiratory Diseases. The CDC contracts with vaccine manufacturers to buy vaccines at reduced rates. Enrolled VFC providers are able to order vaccine through their state VFC program and receive routine vaccines at no cost. This allows routine immunizations to eligible children without high out-of-pocket costs.

Appropriate documentation shall be entered in the member's medical record. It should indicate all attempts to provide immunizations. A receipt of vaccines or proof of prior immunizations; or proof of voluntary refusal of vaccines in the form of a signed statements by the member (if an emancipated minor) or the parent(s), or guardian of the member, shall be entered in the member's medical record. Please contact your PPG or MSO for further details.

The Vaccines for Children (VFC) Program is managed by the California Department of Public Health, Immunization Branch. A full description of the program and potential conditions is located at:

- **https://www.cdph.ca.gov/programs/immunize/Pages/HealthProfessionals.aspx**
- **http://eziz.org/vfc/overview/**

California Children Services (CCS)

CCS is a statewide program that treats children under the age of 21 with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Services manages the CCS program. Providers are required to refer children with certain physical limitations and chronic health conditions or diseases to a CCS paneled provider or CCS Specialty Care Center for care. A full description of the program and potential CCS conditions is located at:

- **http://publichealth.lacounty.gov/cms**
- **http://www.lacare.org/providers/provider-resources/provider-faqs/ccs**

Services for the Developmentally Disabled

The term developmental disability refers to a severe and chronic disability that is attributable to a mental or physical impairment that begins before an individual reaches adulthood. These disabilities include mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions closely related to mental retardation or requiring similar treatment.

For an individual to be assessed in California as having a developmental disability, the disability must begin before the individual's 18th birthday, be expected to continue indefinitely and present a substantial disability. For additional information, please visit the L.A. Care website at: **http://www.lacare.org/dds-0**

Early Intervention/Early Start

A child with or at risk of developmental delay or disability can receive an "Early Start" in the State of California. Teams of service coordinators, health care providers, early intervention specialists, therapists, and parent resource specialists can evaluate and assess an infant or toddler. They can also provide appropriate early intervention services to children eligible for California Early Start. For more information, please refer to the section below; "Primary Care Responsibilities for Care Coordination with Linked and Carved out Services."

Eligibility Criteria

Infants and toddlers from birth to 36 months may be eligible for Early Intervention services through documented evaluation and assessment if they meet one of the criteria listed below:

- Have a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing
- Have established risk conditions of known etiology, with a high probability resulting in delayed development
- Are at high risk of having a substantial developmental disability due to a combination of risk factors

For additional information on Early Intervention and Early Start, please see L.A. Care's website at: **http://www.lacare.org/dds-0**

Primary Care Responsibilities for Care Coordination with Linked and Carved out Services

PCPs are responsible for Coordination of Care for Linked and Carved out Services (i.e. CCS, DDS, Regional Centers, etc.).

Care Managers at L.A. Care or the PPG/MSO are available to assist members, who may need or who are receiving services from out of plan providers and/or programs. This service is available to ensure coordinated service delivery and effective joint case management. The coordination of care and services remains the responsibility of each member's PCP. PPG's and the member's PCP will monitor the following:

- Member referral to and/or utilization of special programs and services
- Member referral to and/or utilization of specialty care, including ensuring consultative notes and summaries are maintained in the medical home records
- Routine medical care, including providing the necessary preventive medical care and services
- Provision of Initial Health Assessments including the Staying Healthy Assessment (SHA)

PPGs/MSOs and PCPs are encouraged to make referrals to local health departments, mental health programs and regional centers.

Out-of-Plan Case Management and Coordination of Care for Linked and Carved out Services

L.A. Care maintains procedures to identify individuals, who may need or who are receiving services from out of plan providers and/or programs. These procedures are established in order to ensure coordinated service delivery and efficient and effective joint case management.

Medical Record Documentation

L.A. Care requires physician offices to maintain a certain level of medical record documentation. L.A. Care will assess records using the DHCS Medical Record Review Guidelines during the Facility Site Review process. A copy of the guidelines are available at: **http://www.lacare.org/providers/provider-resources/provider-faqs/well-child-assessment-forms**.

Behavioral Health

Beacon Health Options is L.A. Care's delegated vendor for non-specialty mental health services. All services listed below are provided to our members:

- Individual, and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication and treatment
- Outpatient laboratory, medications, supplies and supplements
- Psychiatric consultation
- For non-specialty mental health services, please contact:
  - Beacon Health Options
  - Phone Line: 1-877-344-2850

County Specialty Mental Health

There are no changes to County Specialty Mental Health services provided by Los Angeles County Department of Mental Health (DMH) or Substance Use Disorder Treatment by the Department of Public Health (DPH).

- For Specialty Mental Health services, please contact:
  - L.A. County Department of Mental Health (DMH)
  - Phone Line: 1-855-854-7771
- For Specialty Substance Use Disorder treatment, please contact:
  - L.A. County Department of Public Health (DPH)
  - Phone Line: 1-800-564-6600

L.A. Care's Behavioral Health Department

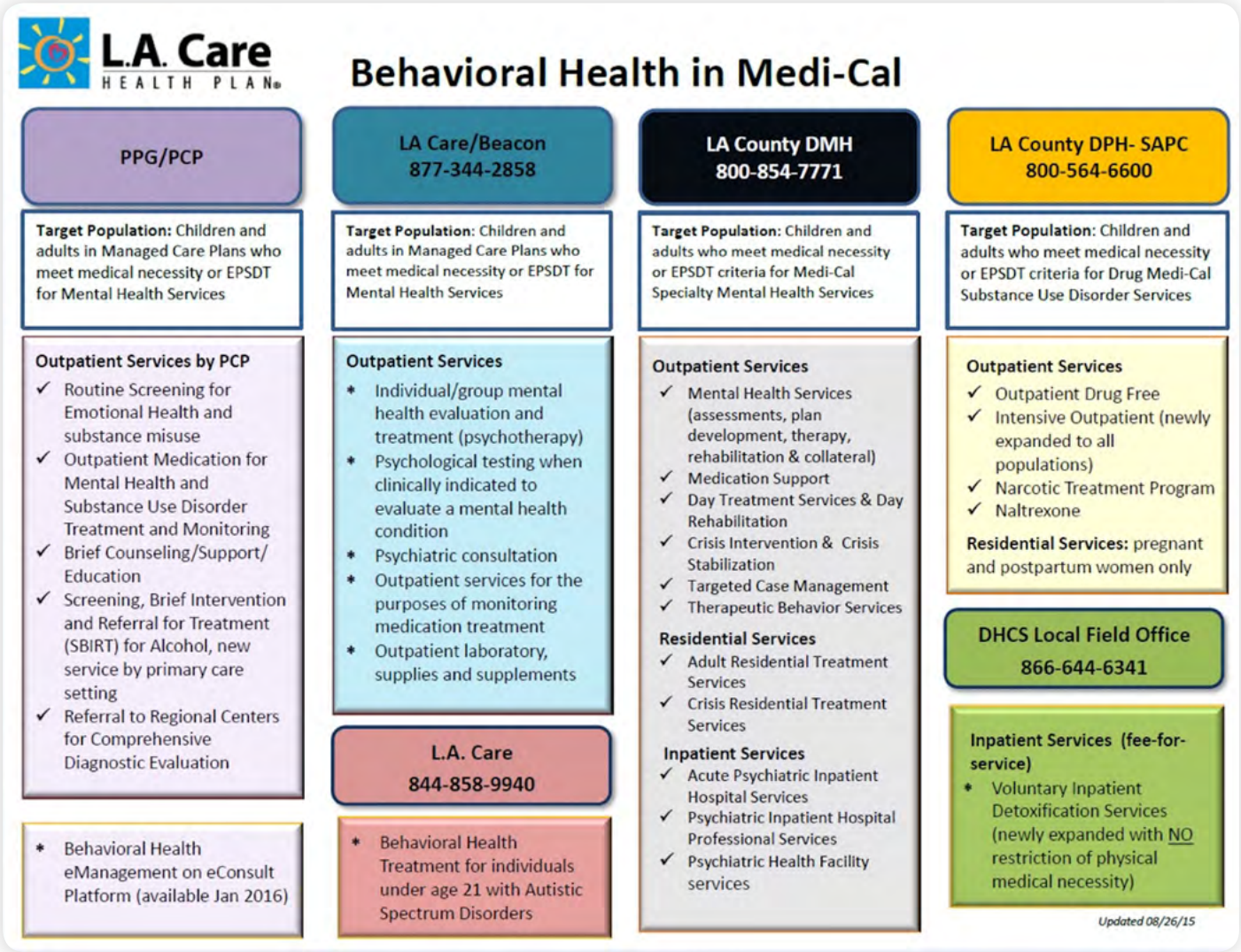
L.A. Care's Behavioral Health Department has licensed behavioral health staff dedicated to supporting you with the services listed below:

- Resolve behavioral health service access issues
- Ensure appropriate clinical transfer in behavioral health system of care
- Assist with service system coordination provided by the Beacon network
- Facilitate Care Coordination between Care Management and PPG Case Managers for behavioral health services
- Educate and train providers and the community
- Support members with behavioral health grievances, appeals and advocacy

This service is available Monday to Friday from 8 a.m. to 5 p.m. You can reach us by phone at 1-844-858-9940 or via email at **behavioralhealth@lacare.org**. Please note that protected health information (PHI) must be sent secured.

The following diagram illustrates services and correlating contact information for L.A. Care's Behavioral Health Medi-Cal program. See figure 3.

Figure 3.


L.A. Care HEALTH PLAN
Behavioral Health in Medi-Cal
PPG/PCP
Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services
Outpatient Services by PCP
✓ Routine Screening for Emotional Health and substance misuse
✓ Outpatient Medication for Mental Health and Substance Use Disorder Treatment and Monitoring
✓ Brief Counseling/Support/ Education
✓ Screening, Brief Intervention and Referral for Treatment (SBIRT) for Alcohol, new service by primary care setting
✓ Referral to Regional Centers for Comprehensive Diagnostic Evaluation
* Behavioral Health eManagement on eConsult Platform (available Jan 2016)
LA Care/Beacon
877-344-2858
Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services
Outpatient Services
* Individual/group mental health evaluation and treatment (psychotherapy)
* Psychological testing when clinically indicated to evaluate a mental health condition
* Psychiatric consultation
* Outpatient services for the purposes of monitoring medication treatment
* Outpatient laboratory, supplies and supplements
L.A. Care
844-858-9940
* Behavioral Health Treatment for individuals under age 21 with Autistic Spectrum Disorders
LA County DMH
800-854-7771
Target Population: Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental Health Services
Outpatient Services
✓ Mental Health Services (assessments, plan development, therapy, rehabilitation & collateral)
✓ Medication Support
✓ Day Treatment Services & Day Rehabilitation
✓ Crisis Intervention & Crisis Stabilization
✓ Targeted Case Management
✓ Therapeutic Behavior Services
Residential Services
✓ Adult Residential Treatment Services
✓ Crisis Residential Treatment Services
Inpatient Services
✓ Acute Psychiatric Inpatient Hospital Services
✓ Psychiatric Inpatient Hospital Professional Services
✓ Psychiatric Health Facility services
LA County DPH- SAPC
800-564-6600
Target Population: Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services
Outpatient Services
✓ Outpatient Drug Free
✓ Intensive Outpatient (newly expanded to all populations)
✓ Narcotic Treatment Program
✓ Naltrexone
Residential Services: pregnant and postpartum women only
DHCS Local Field Office
866-644-6341
Inpatient Services (fee-for-service)
* Voluntary Inpatient Detoxification Services (newly expanded with NO restriction of physical medical necessity)
Updated 08/26/15

Case Management

L.A. Care has a Case Management department (also known as Care Management) with specially trained staff to help members with complex care needs or members at high risk for adverse outcomes. Examples of members with complex needs may include:

- Serious acute or chronic health condition (trauma, new cancer diagnosis)
- multiple uncontrolled health conditions
- complicated social issues (no social support)

Please refer members with complex needs to L.A. Care through the following ways:

- Complete the Care Management Referral Form which is available on the L.A. Care Provider Portal
- Simply call the Care Management department during regular business hours at: 1-844-200-0104

We will work with our members to develop an Individualized Care Plan (ICP) and provide you with updates to the plan after holding an Interdisciplinary Care Team (ICT) meeting with participants most appropriate to address individualized needs.

Managed Long-Term Services and Supports (MLTSS)

MLTSS is a wide range of services that provide support to seniors and individuals with disabilities so that they can remain living safely at home. Services available to L.A. Care members under MLTSS include:

- **In Home Supportive Services (IHSS):** Provides in home care for seniors and people with disabilities. Eligible members can hire anyone they wish to help them with their daily needs. This includes assistance with home chores, personal care assistance, basic medical needs, getting to provider appointments and providing supervision for people with dementia or other mental impairments.
- **Multipurpose Senior Services Program (MSSP):** Provides intensive care coordination services in the home for seniors age 65 and older. An MSSP nurse and social worker team will provide eligible members with a full assessment of their health and social support needs. Additionally the MSSP team will identify, arrange and provide help with accessing resources, monitor the member's wellbeing, and purchase other needed services that may not be available through L.A. Care or other community based programs.
- **Community Based Adult Services (CBAS):** Provides professional nursing services, physical, occupational and speech therapies, socialization, mental health services, therapeutic activities, social services, nutrition and nutritional counseling for people ages 18 and older. CBAS is a day program formerly known as adult day health care center.
- **Long Term Care (LTC):** Provides continuous skilled nursing care to eligible members with physical or mental conditions in a nursing home. The Medi-Cal LTC nursing facility benefit includes room and board and other medically necessary services.

L.A. Care members receiving MLTSS often have complex needs. They may be diagnosed with multiple chronic conditions (functional and cognitive) or may lack social, educational, and economic support. The MLTSS department can help support your patient's access to needed care by:

- Determining if they are IHSS, CBAS, MSSP and LTC eligible
- Coordinating and navigating IHSS, MSSP and CBAS assessment
- Resolving IHSS, MSSP, CBAS and LTC related issues and navigating the grievance and appeals process
- Applying for IHSS and MSSP services
- Coordinating requests for expedited assessments
- Providing temporary services to fill in coordination of care gaps
- Following up with IHSS, MSSP, CBAS, and LTC services to ensure services are being provided
- Referring to local CBAS centers and MSSP sites
- Accessing community based organizations for non-plan services

To find MLTSS Referral forms, go to the L.A. Care website: **http://www.lacare.org/providers/provider-resources/provider-forms**

MLTSS Contact Information

For Managed Long Term Services and Supports questions:

MLTSS Phone Line: 1-855-427-1223

MLTSS Fax Line: 1-213-438-4877

MLTSS Email: **mltss@lacare.org**

L.A. Care Website: **www.lacare.org**

Federal and State Statutes

Federal Statutes

The Centers for Medicare & Medicaid Services(CMS), is part of the Department of Health and Human Services (DHHS). They administer Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and parts of the Patient Protection and the Affordable Care Act (ACA).

The link below provides access to proposed and existing statutes and regulations relevant to CMS.

https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html

State Statutes

The Department of Health Care Services (DHCS) was created and is directly governed by California statutes passed by the California Legislature. These statutes grant DHCS the authority to establish programs and adopt regulations.

The link below provides access to proposed and existing statutes and regulations relevant to the DHCS.

http://www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx

Access and Availability Standards

L.A. Care requires primary care physicians, behavioral health providers, specialists and ancillary providers to be compliant with access and availability standards. The standards are provided below.

Access to Care Quick Tips

Standard[1]	Medi-Cal	L.A. Care Covered	Cal-MediConnect
Primary Care Provider (PCP) Accessibility Standards:			
Routine Primary Care Appointment (Non-Urgent) Services for a patient who is symptomatic but does not require immediate diagnosis and/or treatment.	≤ 10 business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	≤ 48 hours of request if no authorization is required ≤ 96 hours if prior authorization is required		
Emergency Care Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health.	Immediate, 24 hours a day, 7 days per week		
Preventative health examination (Routine)	≤ 10 business days of request		≤ 30 calendar days of request
First Prenatal Visit A periodic health evaluation for a member with no acute medical problem	• ≤ 14 calendar days of request • ≤ 7 calendar days of request for Healthy Kids	≤ 14 calendar days of request	
Staying Healthy Assessment Initial Health Assessment and Individual Health Assessment and Individual Health Education Behavioral Health Assessment (IHEBA)	≤ 120 calendar days from when the member becomes eligible. Members <18 months of age ≤60 calendar days of enrollment or within periodicity timelines as established by the American Academy of Pediatrics (AAP) for ages two and under, whichever is less.		≤ 90 calendar days from when the member becomes eligible.
In-Office Waiting Room Time The time after a scheduled medical appointment a patient is waiting to be taken to an exam room to be seen by the practitioner.	Within 30 minutes		
Specialty Care Provider (SCP) Accessibility Standards:			
Routine Specialty Care Physician Appointment	≤ 15 Business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	• ≤ 48 hours of request if no authorization is required • ≤ 96 hours if prior authorization is required		
Ancillary Care Accessibility Standards:			
Non-Urgent Ancillary Appointment	≤ 15 business days of request		

[1] *Unless otherwise stated, the requirement is 100% compliance.*

next page >

Access and Availability Standards (continued)

Standard[1]	Medi-Cal	L.A. Care Covered	Cal-MediConnect
Behavioral Health Care Accessibility Standards:			
Routine Appointment (includes non-physician behavioral health providers)	≤ 10 business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	≤ 48 hours of request		
Life Threatening Emergency	Immediately		
Non-Life Threatening Emergency	≤ 6 hours of request		
Emergency Services	Immediate, 24 hours a day, 7 days per week		
After Hours Care Standards:			
After Hours Care Physicians (PCP, Behavioral Health Provider and Specialists, or covering physician) are required by contract to provide 24 hours a day, 7 days per week coverage to members. Physicians, or his/her on-call coverage or triage/screening clinician must return urgent calls to member, upon request within 30 minutes. *Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.	• Automated systems must provide emergency 911 instructions; and • Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP, Behavioral Health Provider, Specialist or covering practitioner, or offer a call-back from the PCP, Behavioral Health Provider, Specialist, covering practitioner or triage/screening clinician within 30 minutes If process does not enable the caller to contact the PCP, Behavioral Health Provider, Specialist or covering practitioner directly, the "live" party must have access to a practitioner or triage/screening clinician for both urgent and non-urgent calls.		
Call Return Time (Practitioner's Office) The maximum length of time for PCP, Behavioral Health Provider, Specialist offices, covering practitioner or triage/screening clinician to return a call after hours.	≤ 30 minutes *Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.		
Practitioner Telephone Responsiveness:			
Speed of Telephone Answer (Practitioner's Office) The maximum length of time for practitioner office staff to answer the phone.	≤ 30 seconds		
Member Services Department Call Service Standards:			
Speed of Telephone Answer • The maximum length of time for Member Services Department staff to answer the telephone. • Call Abandonment Rate	• 90% of calls ≤ 30 seconds • NTE 5% in a calendar month		

[1] *Unless otherwise stated, the requirement is 100% compliance.*

1-866-LACARE6 (1-866-522-2736)
www.lacare.org

V. 10/5/2015

Members Rights and Responsibilities

L.A. Care Members have the right to the following:

- **Respectful and courteous treatment:** Members have the right to be treated with respect, dignity and courtesy by their provider and staff. Members have the right to be free from retaliation or force of any kind when making decisions about their care.
- **Privacy and confidentiality:** Members have the right to have their medical records kept confidential. Provider offices must implement and maintain procedures that protect against disclosure of confidential patient information to unauthorized persons. Members also have the right to receive a copy of and request corrections to their medical records. Physicians must abide by California State minor consent laws. Members have the right to be counseled on their rights to confidentiality and members consent is required prior to the release of confidential information, unless such consent is not required.
- **Choice and involvement in their care:** Members have the right to receive information about their health plan, services, and providers. Members have the right to choose their Primary Care Provider (PCP) from L.A. Care's provider directory. Members also have the right to obtain appointments within access standards. Members have the right to talk with their provider about any care provided or recommended. Members have the right to discuss all treatment options, and participate in making decisions about their care. Members have the right to a second opinion. Members have the right to speak candidly to their provider about appropriate or medically necessary treatment options for their condition. Members have the right to deny treatment. Members have the right to decide in advance how they want to be cared for in case of a life-threatening illness or injury. Members also have the right to assist with the formulation of their advanced directives. Written policies and procedures respecting advanced directives shall be developed in accordance.
- **Voice concerns:** Members have the right to grieve about L.A. Care and/or its affiliated providers. They also have the right to receive care without fear of losing their benefits. L.A. Care will help members with the grievance process. If members don't agree with a decision, they have the right to appeal. Members have the right to disenroll from their health plan whenever they want. As a Medi-Cal member, they have the right to request a State Fair Hearing, including information on the circumstances under which an expedited fair hearing is possible.
- **Service outside of L.A. Care's provider network:** Members have the right to receive emergency or urgent services as well as family planning and sexually transmitted disease services outside of their health plan's network. Members also have access to Federally Qualified Health Centers and Indian Health Services Facilities.
- **Service and information:** Members have the right to request an interpreter at no charge and not use a family member or a friend to translate for them. Members have the right to access the Member Handbook and other information in another language or format, including; braille, large size print, and audio format upon request.
- **Know their rights:** Members have the right to receive information about their rights and responsibilities. Members have the right to make recommendations about their rights and responsibilities. Members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

As a member of L.A. Care members have the responsibility to:

- **Act courteously and respectfully:** Members are responsible for treating providers and staff with courtesy and respect. Members are responsible for being on time for their visits or calling your office at least 24 hours before the visit to cancel or reschedule.
- **Give up-to-date, accurate and complete information:** Members are responsible for giving correct information and as much information as they can to all of their providers and L.A. Care. Members are responsible for getting regular check-ups and telling their provider about health problems before they become serious.
- **Members should follow their provider's advice and take part in their care:** Members are responsible for talking about their health care needs with their provider, developing and agreeing on goals, doing their best to understand their health problems following the treatment plans and instructions you both agree on.
- **Use the Emergency Room only in an emergency:** Members are responsible for using the emergency room in case of an emergency or as directed by their provider.
- **Report wrong doing:** Members are responsible for reporting health care fraud or wrong doing to L.A. Care. Members can do this without giving their name by calling the L.A. Care Fraud and Abuse Hotline toll-free at 1-800-400-4889.

To access the L.A. Care Member Rights section on the website go to **http://www.lacare.org/members/member-protection/member-rights**.

Cultural and Linguistic Services

L.A. Care provides an array of cultural and linguistic services and resources to assist you in delivering effective patient-centered care. The following is a quick guide to help you and your staff understand the state and federal regulatory requirements that guide cultural and linguistic services to ensure compliance.

Bilingual Staff

Effective communication though qualified interpreters improves quality of care, increases member satisfaction and minimizes the risk of liability and malpractice lawsuits. L.A. Care offers no cost qualified interpreting services to you and your members in an effort to discourage the use of bilingual staff as interpreters. If a member of your staff is bilingual and utilizes the second language to interact with members, it is important they are qualified and proficient in English and the other language with proper training and education.

Please maintain the following documentation for your qualified bilingual staff:

- Certification for medical interpreters
- Number of years of service employed as an interpreter (e.g. resume)
- Certificate of completion interpreter training program
- Bilingual skills self-assessment

Bilingual Language Skills Self-Assessment Tool

The self-assessment tool is a resource to assist you in identifying language skills and resources existing in your office. It can be used to document bilingual skills of your staff before the professional assessment. The self-assessment tool is included in Section 1 of "What you need to know" in the Provider Toolkit. The assessment should be conducted annually for office staff and every three years for physicians.

- To order the toolkits go to **https://external.lacare.org/HealtheForm/**
- To download the toolkits go to **http://www.lacare.org/providers/provider-resources/provider-tool-kits**

Interpreting Services

Qualified interpreting services are essential to communicating effectively with limited English proficient members. L.A. Care's face-to-face and telephonic interpreting services are available to you and your staff at no charge. Interpreting services also include American Sign Language (ASL). The following information describes how to access these services:

- Face-to-face Interpreting Services
  - Call 1-888-839-9909 to request an interpreter for medical appointments.
- Telephonic Interpreting Services
  - Call 1-888-930-3031 to be connected with an interpreter over the phone immediately.
- California Relay Services
  - Call 711 to communicate with the deaf and hard of hearing members over the phone.

Key Things to Remember

- Inform members of the availability of no-cost 24/7 interpreting services including ASL.
- Document the member's preferred language in the medical chart.
- Discourage use of friends, family members and minors as interpreters.
- Document member's request/refusal of interpreting services in the medical chart after no-cost interpreting services are offered to them.

Language Poster

The language poster is an effective way to let your staff and members know about availability of no cost interpreting services and how to access the services from L.A. Care. The poster is translated into 14 languages and should be posted at the key points of contact such as front office and exam rooms.

To order the posters, go to **https://external.lacare.org/HealtheForm/**

Telephonic Interpreting Card

Keep the card available for easy access to no cost telephonic interpreters.

To order the telephonic card, go to **https://external.lacare.org/HealtheForm/**

Cultural and Linguistic Training

The following workshops are a rapid way to learn how to deliver culturally and linguistically appropriate care to diverse member populations. The below instructor-led classroom or Learning Management System (LMS) trainings are available at no cost for your convenience:

- Interpreting Services
- Cultural Competency
- Disability Awareness

To schedule classroom training sessions at your facility, contact **CLStrainings@lacare.org**

To access online LMS, go to **https://lacareuniversity.torchlms.com**

Cultural and Linguistic Provider Toolkit

The provider toolkit is a comprehensive guide to culturally and linguistically appropriate services. It is organized in five sections which contain helpful information and tools that can be reproduced as needed.

- To order the toolkits, go to **https://external.lacare.org/HealtheForm/**.
- To download the toolkits, go to **http://www.lacare.org/providers/provider-resources/provider-tool-kits**.

Online Resource Directory

To refer the members to cultural and linguistic community services, go to **http://www.healthycity.org/**.

The following are suggested best practices. The information consists of useful reminders and tips providers and medical office staff can utilize to enhance a positive customer service experience.

Build rapport with the member

- Address members by their last name if the member's preference of greeting is not clear
- Focus your attention on members when addressing them
- Learn basic words in your member's primary language, like "hello" or "thank you"
- Explain the different roles performed by office staff

Make sure members know your role

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed and how the provider coordinates specialty care
- Have instructions professionally translated and available in the common language(s) spoken by your member panel
- It is not necessary to raise the volume of your voice if the issue is language comprehension and not hearing

Keep members' expectations realistic

- Inform members of delays or extended wait times

Work to build members trust

- Inform members of office procedures, such as when they can expect a call with lab results, how follow-up appointments are scheduled and routine wait times

Determine if the member needs an interpreter for the visit

- Document the member's preferred language in the member chart
- Have an interpreter access plan. Use of interpreters with a medical background is strongly encouraged, rather than family, minors or friends of the member
- Assess your bilingual clinical staff for interpreter abilities

Give members the information they need

- Have health education materials in languages that reflect your membership
- Offer handouts such as immunization guidelines for adults and children, screening guidelines and culturally relevant dietary guidelines for diabetes or weight loss

Make sure members know what to do

- Review any follow-up procedures with the member before they leave your office
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests and whether or not a follow-up appointment is necessary

Develop pre-printed simple handouts of frequently used instructions and translate the handouts into the common language(s) spoken by your membership

Styles of Speech

People vary greatly in the length of time between comments and responses. The speed of their speech and their willingness to interrupt may vary.

- Tolerate gaps between questions and answers; impatience can be seen as a sign of disrespect
- Listen to the volume and speed of the member's speech as well as the content. Modify your own speech to more closely match that of the member to make them more comfortable
- Rapid exchanges and even interruptions are a part of some conversational styles
- Do not be offended if a member interrupts you
- Stay aware of your interruption patterns, especially if the member is older than you are

Eye Contact

The way people interpret various types of eye contact is tied to cultural background.

- Look people directly in the eyes to demonstrate communication engagement
- For other cultures, direct eye contact is considered rude or disrespectful. Never force a member to make eye contact with you.
- If a member seems uncomfortable with direct eye contact, try sitting next to them instead of across from them

Body Language

- Follow the member's lead on physical distance and contact
- Stay sensitive to those who do not feel comfortable
- Gestures can have different meanings
- Be conservative in your own use of gestures and body language
- Do not interpret member's feelings or level of pain solely from facial expressions

Gently Guide Member Conversation

English language predisposes us to a direct communication style however, other languages and cultures differ.

- Non English speaking members or individuals from diverse cultural backgrounds may be less likely to ask questions

Facilitate member-centered communication

- Avoid questions that can be answered with "yes" or "no"
- Steer the member back to the topic by asking a question that clearly demonstrates that you are listening
- Some members can tell you more about their health through story telling than by answering direct questions

Thank you for taking this training. Please make sure to sign and attest that you have read and understood this information and provide a copy to your PPG or MSO. If you would like more information, please refer to the L.A. Care Provider Manual. If you have additional questions, please contact your PPG or MSO.

Produced by the L.A. Care Provider Network Operations department.

Critical Incident (CI) Training for Delegates

L.A. Care HEALTH PLAN®

For All of L.A.

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Learning Objectives

- Definition and importance of Critical Incident Reporting
- Recognize reportable Critical Incidents
- Learn about Critical Incident categories
- Understand the Critical Incident reporting process and timeline

CI Definition & Reporting

Definition:

A *Critical Incident* is any incident in which the enrollee or member is exposed to any of the following: abuse, neglect, exploitation, a serious, life threatening medical event requiring immediate emergency evaluation by a medical professional, or the disappearance, suicide attempt, restraint, seclusion, unexpected death, or other catastrophes and unusual occurrences of the enrollee.

Why Report a CI?

Under the requirements set forth by the California Department of Health Care Services (DHCS) 42 CRF 438.66, APL 21-26 and CCR Title 22 §72541, CI concerns must be reported to the local law enforcement agency, long-term care (LTC) ombudsman, local health officer, and district office (DO) to protect the health, safety and welfare of L.A. Care members.

Critical Incident reporting to DHCS is required by L.A. Care for members under Dual Special Needs Plan (D-SNP) and Medi-Cal (MCLA).

Recognize a Critical Incident

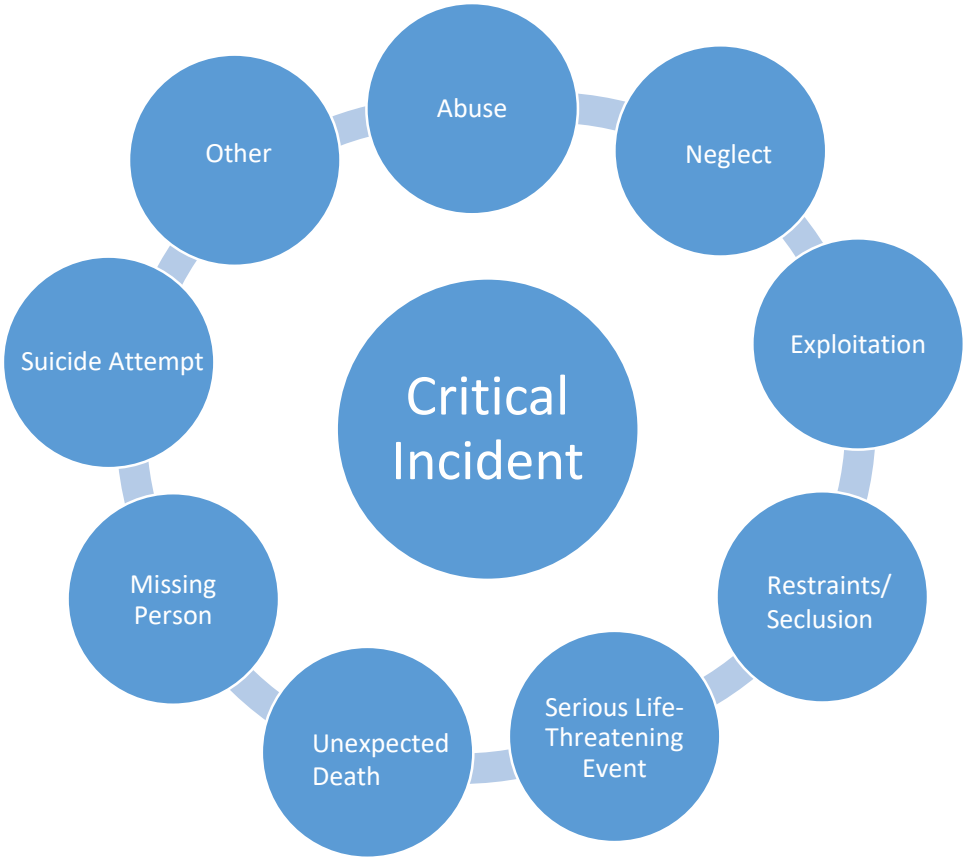
If your position includes contact with members or their care information, you may be notified of a Critical Incident by:

- Member verbally expressing the incident to you
- A caregiver, family member, case manager or any member-facing individual informing you of member's situation
- Member is admitted for a suicide attempt, reported missing, or any applicable CI events

If notified of a Critical Incident, you must always take the report seriously and act in a timely manner.

Reportable Events

As defined by L.A. Care's QI-027 Critical Incident Reporting & Tracking policy:



Please immediately notify the local authority to ensure patient safety if a CI Reportable Event occurs.

How to Report a Critical Incident

It is crucial to notify the appropriate authorities in a timely manner!

NOTIFY

- CIs must be notified to the proper authorities and reporting agencies

DOCUMENT

- All reported critical incidents should be tracked in the CI Tracking Log.

REPORT

- Within **15 days** after the end of each quarter, the CI Tracking Log is reported to CI@lacare.org via a secured/protected encrypted email

Key Resources

Please refer to these guidelines and resources for additional information regarding CI:

- L.A. Care Policy & Procedure: Critical Incident Reporting QI-027
- 42 CFR 438.66 - Centers for Medicare and Medicaid Services, Department of Health and Human Service
- AFL 21-26 – California Department of Public Health
- CCR Title 22 §72541 - Barclays Official California Code of Regulations
- CI@lacare.org- Contact for any CI-related questions and concerns

L.A. Care Medicare Plus™
(HMO D-SNP)

L.A. Care HEALTH PLAN®
For All of L.A.

2024 D-SNP Provider Model of Care Training

Training Topics

- Training Objectives
- Dual Special Needs Plan (D-SNP) – Member Benefit Overview
- What is the D-SNP Model of Care (MOC)?
- Model of Care Requirements and Provider Roles and Responsibilities
    - Description of L.A. Care's DSNP Population
    - Care Coordination
    - Provider Network
    - Quality Measurements and Performance Improvement

MOC Training Objectives

Objectives:

- Overview
- Outline the basic components of L.A. Care's D-SNP Model of Care (MOC), including Member Benefits
- Describe L.A. Care's MOC
- Describe the essential role of L.A. Care Providers in the implementation of the MOC, including participation in the member's:
    - Health Risk Assessment (HRA)
    - Individualized Care Plan (ICP)
    - Interdisciplinary Care Team (ICT)
    - Face to Face Encounter

CMS Requirements Overview

- The Centers for Medicare & Medicaid Services (CMS) want all healthcare providers who see members regularly to get training on the D-SNP Model of Care (MOC)

- The MOC helps healthcare providers understand and take care of special needs of their members as well as giving guidance on delivering coordinated care and care management

- To comply with the requirement, this training will teach about the MOC and how L.A. Care and their contracted providers can work together to successfully deliver the Model of Care

Who can enroll in L.A. Care's D-SNP?

- An eligible member must meet all the following requirements to be enrolled:
  - Enrolled in Medicare Part A (Hospital)
  - Enrolled in Medicare Part B (Medical)
  - Lives in Los Angeles County
  - Meets the California Medicaid requirements for QMB+, SLMB+ or FBDE
  - Enrolled in a Medi-Cal Managed Care Plan
  - Must be 21 years of age or older

- Enrollment begins during the Annual Election Period (2023 October 15 – December 7)

Ongoing Eligibility Verification

If you're an L.A. Care, Medicare Plus member, you may be disenrolled from the plan for these reasons:

- If member no longer qualifies for Medi-cal, L.A. Care will continue to provide all plan-covered Medicare benefits up to 3 months before being dis-enrolled.
    - the member will go on Medicare Fee-For-Service. If Medi-Cal is regained within 3 months, the member returns to L.A Care’s D-SNP plan.

- If you're away from L.A. Care's service area temporarily for up to 6 months or move permanently, you'll be removed at the beginning of the following month after the 6th month.

D-SNP Member Billing

- If you're a member of L.A. Care Medicare Plus, you get both Medicare and full Medi-Cal benefits.
- You won't be charged extra for Medicare costs like deductibles, coinsurance, or copayments.
- Medicare pays first for services, and Medi-Cal pays second, but for things covered by both, like Skilled Nursing Facility care, Medicare pays first before Medi-Cal helps.

Provider Model of Care (MOC) Training Requirements

- L.A. Care keeps records of training for all providers (both in and out-of-network) who take care of L.A. Care D-SNP members.

- All staff involved in managing L.A Care's D-SNP members care must complete the MOC training when the member enrolls and again every year.

- The training is available on the Provider website and can be used as a resource to meet the initial and yearly MOC training needs.

New for 2024: Training Requirements

Dementia Care Specific Training

- DHCS requires **providers** to complete MOC training as well as Dementia Care Aware training.
- Dementia care **specialist** will also be required to complete dementia care training
- The training covers important topics like Alzheimer's Disease and other dementias, their symptoms, behaviors, communication problems, and community resources for members and caregivers
- Dementia care specialists will also be a required participant of the members interdisciplinary care team (ICT)
- **Mild Cognitive Impairment (MCI): will be a performance measure for 2024, reported annually**
    - Members must receive cognitive screen with approved tools
    - Denominator: All members 65+, Numerator: who received a cognitive screen
    - Providers will only be able to bill and report if completed Dementia Care Aware specific training

What is the L.A. Care Model of Care (MOC)?

The MOC is L.A. Care's blueprint for the care of D-SNP members; it is used to coordinate comprehensive care for vulnerable and at-risk members, focusing on their health conditions and social factors

- It helps providers by improving quality, access, affordability, and care integration

- And helps members by ensuring smooth care transitions, promotes preventive health services, appropriate utilization of benefits and ultimately by improving member health outcomes.

Model of Care Provider Roles and Responsibilities: PCP

The member's Primary Care Provider (PCP) plays a crucial role in their care. The PCP helps by doing the following:

- Reviewing the member's Health Risk Assessment (HRA)
- Having Face-to-Face visits or tele-visits with the member every 12 months
- Assisting with the development and communication of the member's Individualized Care Plan (ICP)
- Attending and taking part in the member's Interdisciplinary Care Team meetings
- Joining in Quality-of-Care initiatives like completing Annual Wellness Visits
    - Where Advanced Care Planning is discussed and completed

Coordination of Medicare/Medi-Cal

It's important to know the following about D-SNP benefits:

- Both Medicare and Medi-Cal benefits must work together and providers must understand both programs
- Support with maintaining Medi-cal coverage is a key component
- Members can file appeals and grievances with both Medicare and Medi-Cal
- Coordination is needed with a member's MCP if Medi-Cal and Medicare plans don't match up

Model of Care Roles and Responsibilities: PPG

L.A. Care's D-SNP Model of Care helps PPG partners support the member by:

- Improving communication with the member, PCP, ICT, and Medi-Cal services
- Providing Care Management for low-risk members through Health Risk Assessment
- Creating and executing Individualized Care Plans to address each member's needs.
- Holding regular Interdisciplinary Care meetings to review member needs and ensure everyone is on the same page.
- Assisting with care transitions and encouraging members to have an annual Face-to-Face visit.

Sections of the Model of Care (MOC)

The MOC is comprised of four sections:

- MOC 1: Description of the D-SNP Population
- MOC 2: Care Coordination (through a dedicated care management team and program)
- MOC 3: Provider Network
- MOC 4: Quality Measurements and Performance Improvement

Each element has corresponding factors L.A. Care must meet when implementing the MOC. Those factors will be outlined within this training.

MOC 1: Description of Member Population

L.A. Care's provider partners are responsible for supporting the D-SNP Population, which includes:

- Members with disabilities and those who are blind or disabled (ABD)
- Have multiple health conditions, complex care needs, and cognitive/behavioral conditions.

Description of Most Vulnerable Members

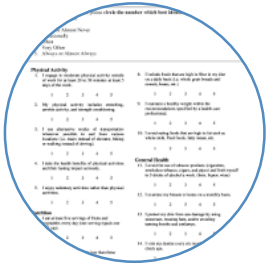
L.A. Care identifies the D-SNP member population at greatest risk and directs care management services and resources toward them

L.A. Care's most vulnerable members have many characteristics, such as:

- Having complex or multiple chronic conditions
- Being disabled or frail
- Facing socioeconomic challenges
- Having dementia-related disorders
- Being near the end of life
- Dealing with multiple medications (polypharmacy)

MOC 2: Care Coordination

D-SNP members are required to have the following elements completed:



Health Risk Assessment

Face to Face Encounter

Individualized Care Plan

Interdisciplinary Care Team

Care Transition Protocols

Care Coordination Overview

Coordination of Care is how L.A. Care organizes and shares the member's health needs and preferences with their Interdisciplinary Care Team (ICT).

It involves:

- Health Risk Assessment (HRA) to understand each member's risk level (Low, High, Complex) within 90 days of enrollment
- Creating an Individualized Care Plan (ICP) within 45 calendar days (30 business days) of HRA Completion
- Meeting face-to-face with each member within 12 months after they join.
- Forming an Interdisciplinary Care Team (ICT) meetings to insure care coordination
    - At least yearly, due to TOC, or change in health condition
- Following protocols for Transitions of Care (TOC) and Continuity of Care (COC)
    - Timely engagement and member encounter (Telehealth/F2F/In-home) within 30 days following discharge

HRA Components

L.A. Care does Health Risk Assessments (HRAs) to find members' medical, mental, and other health needs and risks.

- An HRA will be completed within 90 days of joining and do one every year after that, members can refuse completion if not agreeable
- The HRA will be used to complete the member Individualized Care Plan
- HRAs show the member's risk level and how often they should be contacted
- PPGs will be delivered completed HRAs for Low Risk members who are delegated to them for Care Coordination

HRA components

PPGs:

Are to encourage member completion of HRA and have it mailed back when received through mail or printed from L.A. Care's website

New For 2024:

- If a caregiver is identified during the HRA, the Care Manager will complete a Benjamin Rose Caregiver Strain assessment
- For specific populations social needs related to housing, food security, and transportation will be identified.
- An HRA must be completed to be considered for supplemental benefits; HRAs will also include questions about Advanced Care Planning (ACP).

Individualized Care Plan (ICP) Regulations

According to regulations, all SNPs must create and follow an ICP for each member

- ICPs will be developed using HRA results and health data, even if the member didn't participate within 45 calendar (30 business days) of HRA completion
- Care Managers (from PPG and L.A. Care) work with the member, their PCP, and other ICT participants to prepare, implement, evaluate, and update the ICP
- The ICP will include member specific, measurable and timely goals that account for any member barriers
- When the ICP is updated, the member gets a physical copy in their preferred language/format. External ICT participants can also access it upon request, using secure fax, email, or mail.

Interdisciplinary Care Team (ICT)

According to regulations, all D-SNP plans must use an ICT for each member's care management

L.A. Care and PPGs will have ICT meetings based on the member's risk level and are expected to:

- Attend member ICT meetings when possible, including dementia specialists and palliative care teams
- Keep copies of the HRA, ICP, ICT worksheets, and transition of care notifications
- Communicate and coordinate care among ICT participants
- All members must have at least one ICT meeting every year; more if needed due to changes in condition or ICT recommendation

ICT Coordination Participants and Process

The Care Manager (PPG or L.A. Care) is responsible for identifying the participants of the ICT

ICT participants always include the member, primary care physician, and assigned care manager. ICT participants may also include but are not limited to:

- Member's friends or family members
- Member's IHSS worker
- Social workers
- Specialists
- Pharmacist
- Dementia Care Specialist (Requires additional training)
- Palliative Care Team
- Other participants as needed or requested by the member

Face-to-Face Encounters

According to regulations, all D-SNPs must offer face-to-face meetings with each member for health care or care coordination.

- These meetings should happen at least once a year, starting within the first 12 months of joining
- During the face-to-face meeting, the member can talk with people like their PCP, Specialist, or someone from the ICT or care management team
- The meeting can be in-person or through a real-time video call. It should be done when possible and with the member's agreement
- For Face-to-Face encounters, Providers should code the visit and make this data available to L.A. Care (claim, encounter, adult wellness exam form).
- **Annual Wellness Visits can be leveraged to complete this requirement, while addressing Advanced Care Planning and form completion if member desires**

Transitions of Care (TOC) Element and CMS requirements

According to regulation, all D-SNPs' Care Management teams, PPGs and Providers, are responsible for:

- Following L.A. Care's Transition of Care Protocol
- Informing the ICT of any changes in the member's health or care plan due to transitions
- Providing transitional care management services and communications
- Ensuring an understanding of LTSS, DME and community based services available to members

Transitions of Care (TOC): Provider Responsibility

The care management team (either PPG or L.A. Care) helps members during transitions from the hospital or other care settings.

L.A. Care has a plan for transitions and works with Providers to make sure:

- They are told promptly about a member going into or leaving the hospital.
- The Care Management team visits or calls the member within 72 hours after leaving the hospital
- They coordinate care and services, review medications, and schedule follow-up appointments
- They have a face-to-face visit with the member either before or within 30 days after leaving the hospital.

New for 2024: Palliative Care

Palliative Care:

D-SNPs are required to deliver Palliative Care services modeled after the Medi-cal program and are required to provide at minimum:

- 1. Advance Care Planning
- 2. Palliative Care Assessment and Consultation
- 3. Plan of Care
- 4. Palliative Care Team of doctors, nurses, social workers, chaplain, and other specialists.
- 5. Care Coordination
- 6. Pain and Symptom Management
- 7. Mental Health and Medical Social Services

PPGs will be responsible for knowing about this requirement and referring members back to L.A. Care if need for Palliative Care arises

New for 2024: Enhanced Care Coordination

L.A. Care will be required to deliver Enhanced Care Management-like services to specific D-SNP members

These members will get extra help in coordinating their care and will include the following populations of focus:

- Members at risk for avoidable hospitalization or ER utilization
- Adults living in the community and at risk for institutionalization
- Adult nursing facility residents transitioning to the community
- Pregnancy, Postpartum and Birth Equity

PPGs will be responsible for knowing about this requirement and referring members back to L.A. Care if need for Enhanced Care Coordination arises

MOC 3: Provider Network Responsibilities

Network Providers have important responsibilities, including:

- Evidencing provider expertise and specialization
- Using evidence-based clinical guidelines and protocols to ensure members get the right care at the right time and understanding the process when deviating from them
- Participating in all elements of members care coordination- HRA/ICP/ICT/TOC
- Completing and attesting to Model of Care training initially and yearly thereafter including any additional suggested trainings such as Dementia Care Aware

MOC 4: Quality Measurement and Performance Improvement

L.A. Care's responsibilities include both for L.A Care and PPG delegated functions:

- Making a plan to improve the access, quality, timeliness of care
- Improve coordination, utilization of care and the member experience
- Setting goals and health outcomes that match the MOC (Like HRA/ICP/ICT/TOC)
- Following all the rules set by regulators (like NCQA, CMS, etc.) and reporting the details
- Sharing information about the quality and performance of care in the SNP and the MOC

Regulatory References

CMS Medicare Managed Care Manual for Special Needs Plans (SNPs): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf

CMS Requirements for Quality Assessment: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf

CMS SNP Model of Care (MOC) information: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

NCQA MOC Approval Process: https://snpmoc.ncqa.org/

Electronic Code of Federal Regulation: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422

NCQA MOC Scoring Guidelines: https://snpmoc.ncqa.org/scoring-guidelines-2023

DHCS DSNP Policy Guide CY2024: https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-CalAIM-D-SNP-Policy-Guide-2024-June.pdf

Dementia Care Aware Training: https://www.dementiacareaware.org/

Reporting Tech-Specs: https://www.dhcs.ca.gov/Documents/D-SNP-Reporting-Requirements-Technical-Specifications-6-29-23.pdf

Dementia Care Resource: https://www.dementiacareaware.org/wp-content/uploads/2023/04/dca-faq-care-provider-R6.pdf

Attestation for L.A. Care Health Plan Trainings

As a contracted entity with L.A. Care Health Plan, you and your staff must participate in the New Provider Training as part of the onboarding process, and when Ad hoc trainings or updates are required. You must have all required staff in attendance of training(s), legibly complete the sign-in sheet (All Fields), and the facilitator or Office Manager must attest below that the staff listed on the corresponding sign-in sheet were in attendance for the entire presentation. **Signing this attestation confirms that you and your staff have completed the required training and have received and reviewed "The New Provider Orientation Handbook, provided by L.A. Care Health Plan."** As part of L.A. Care Health Plan's oversight and monitoring activities, L.A. Care Health Plan will review sign-in sheets, attestations, and any other corresponding materials to ensure they are complete, accurate, true, and meet any required deadlines.

Please indicate which training has been completed by you and your staff.

L.A. Care Health Plan New Provider Training _____ Date Completed:

L.A. Care Health Plan Sign-in Sheet _____ Date Completed:

L.A. Care Model of Care Training _____ Date Completed:

Other (please print title)_____ Date Completed:

By signing below, I attest that staff listed on the corresponding sign-in sheet representing my organization,_____

a contracted entity with L.A. Care Health Plan, have received and reviewed a copy of both the L.A. Care New Provider Orientation Handbook and Model of Care Training as well as completed other training(s) listed above.

I attest that my organization will furnish copies of sign-in sheets, attestations, and any other related material at the request of L.A. Care Health Plan.

Name of facilitator/office manager/individual provider: _____

Title: _____

Signature:_____ Date:_____

Email:_____ Phone: _____

*LA CARE FORMS AND THE LANGUAGE CONTAINED HEREIN ARE NOT TO BE ALTERED

L.A. Care Sign-In Sheet

Name of PPG/PCP/Specialist/Hospital/Other: _____

Training Location: _____

Facilitator Name: _____

Date: _____ **Time:** _____ **Phone:**_____

Name of Training: _____

Print Name (first, last)	Signature	Job Title	Email Address

By signing your name above, you attest that you have completed the training or attended the event indicated on this sign-in sheet. 09/21/2021aw

*LA CARE FORMS AND THE LANGUAGE CONTAINED HEREIN ARE NOT TO BE ALTERED. IF A SECOND SHEET IS NEEDED, PRINT AND LABEL AS PAGE 2.

Note: Please complete all highlighted fields

Health Net®
COMMUNITY SOLUTIONS

CONFIRMATION OF NEW PROVIDER TRAINING

Please complete the following and submit it within 48 hours via email to HN_Provider_Relations@healthnet.com, or send it via fax to 1-855-863-5987.

REQUIRED: Initial #1 OR #2

1. _____ (initial) I have received the new provider training materials from Health Net Community Solutions, Inc. (Health Net), reviewed them for training purposes, and understand essential components of Health Net's Medi-Cal plan, including basic information about public health programs available to Health Net Medi-Cal members, Health Net's quality improvement program, and interpreter services and provider tools to care for diverse populations.

OR

2. _____ (initial) I have completed Health Net's new provider training online on the provider website and understand essential components of Health Net's Medi-Cal plan, including basic information about public health programs available to Health Net Medi-Cal members, Health Net's quality improvement program, and interpreter services and provider tools to care for diverse populations.

REQUIRED: Initial #3

3. _____ (initial) In addition, I understand my responsibilities related to Health Net's Medi-Cal managed care program services, policies and procedures, and ways to communicate between providers, members and Health Net. I understand how to access and find information on Health Net's provider website about Medi-Cal benefits and services, claims and payment policies, California Children's Services (CCS)-eligible conditions and referral processes, case management services, tools to care for a diverse population, and operations manuals located under *Working with Health Net > Contractual > Provider Library.*

_____ _____ _____
Provider name (PRINT) Provider signature Date

_____
Provider address (street, city, ZIP)

_____ _____ _____
Phone number Email address Tax identification number (TIN)

INTERNAL USE ONLY

_____ _____ _____
Received date Data entry date Provider representative

New Provider Orientation

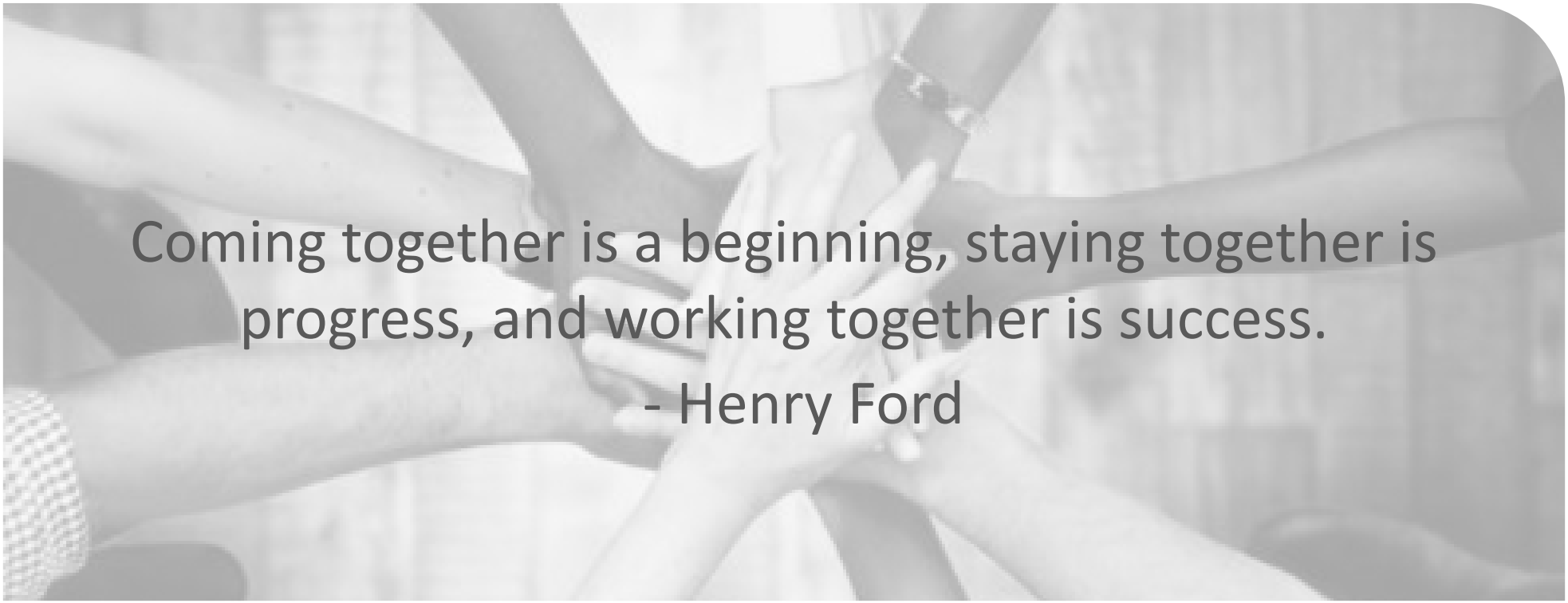
2023

MOLINA® HEALTHCARE

Welcome to Molina Healthcare

MOLINA® HEALTHCARE

Reflection


Coming together is a beginning, staying together is progress, and working together is success.
- Henry Ford

Molina Healthcare values provider relationships

- Molina Healthcare of California (Molina) strongly values our relationship with you and welcomes you to our Molina family and network of providers. As a health plan founded by a physician, Molina shares a common mission with our providers which includes:
  - Ensuring the delivery of high-quality health care services
  - Increasing the delivery of preventive health services and access to care
  - Removing barriers to health care
  - Advocating strongly for the well-being of our members and their families
  - Ensuring health care is available to those who are vulnerable and most in need
  - Providing the right care, in the right setting, at the right time

MOLINA® HEALTHCARE

Required by regulators

Molina Healthcare Provider Services offers on-going education and training to contracted network/delegates to ensure comprehensive instruction is offered to providers.
Topics include Molina operational processes and requirements to ensure adherence to compliance standards set forth by regulatory bodies: the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC).

Additional in-services/training will be offered to providers for continuum of education and upon request.

Required by regulators

- Department Healthcare Services (DHCS)
- Department Managed Healthcare (DMHC)

At Molina Healthcare of California, we prioritize the compliance of our network providers with the Medi-Cal Managed Care program.

We ensure that all providers receive comprehensive training to guarantee their full compliance with the contract and all relevant federal and state statutes, regulations, all plan letters and policy letters.

To access the necessary regulatory information, please use the links provided. Your commitment to compliance is vital to our shared success.

Additional in-services/training will be offered to providers for continuum of education and upon request.

MOLINA® HEALTHCARE

Molina Healthcare - California

Partial map of California

Molina operates in seven counties

- Medi-Cal
- Medicare
- Marketplace

MOLINA® HEALTHCARE

Online resources and important contacts

MOLINA® HEALTHCARE

Online resources

As a key partner of Molina, access to the provider manuals and other resources are available to you via the Molina website. Molina provides a wide variety of information to answer your questions and assist in ongoing education and compliance with state, federal, and regulatory requirements.

Please note, the provider manual is an extension of the provider agreement. Providers and vendors are contractually obligated to comply with requirements and operational procedures addressed in the provider manual.

Name	LOB	Link
Molina website	All	https://www.molinahealthcare.com/members/ca/en-US/pages/home.aspx
Provider manual	Marketplace	https://www.molinamarketplace.com/marketplace/ca/en-us/Providers/~/media/Molina/PublicWebsite/PDF/Providers/ca/Marketplace/2023%20Marketplace%20Provider%20Manual.pdf
	Medicare	https://www.molinahealthcare.com/~/media/Molina/PublicWebsite/PDF/Providers/common/medicare/provider-manual-ca.pdf
	Medi-Cal	https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ca/MediCal/Medi-Cal-Provider-Manual.pdf

MOLINA® HEALTHCARE

Molina contact information

Radiology authorizations
Phone: (855) 714-2415
Fax: (877) 731-7218

Medi-Cal pharmacy authorizations
Phone: (855) 322-4075
Fax: (866) 508-6445

Medi-Cal Member Services - benefits/eligibility/non-emergent transportation
Phone: (888) 665-4621
Fax: (310) 507-6186
TTY/TDD: 711

Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802
Main Phone (562) 499-6191
Toll Free (888) 665-4621 (TTY : 711)
Business Hours: Monday to Friday
7:30 a.m. - 5:30 p.m.

Provider Services
Phone (855) 322-4075
Fax (562) 951-1529

Fraud and abuse tip line
Phone: (866) 606-3889

Medi-Cal authorizations
Phone: (844) 557-8434
Fax: (800) 811-4804

MOLINA® HEALTHCARE

Molina contact information Health Net

Health Net member services (Medi-Cal Los Angeles)
Phone: 800-675-6110

Molina Member Services (Medi-Cal- Riverside County and San Bernardino County)
Phone: 888-665-4621

Health Net Nurse Advice Line
The Nurse Advice Line is staffed after business hours by registered nurses for Member assistance and referral.
Phone: 800-675-6110

Health Net Website
Health Net's website offers information on member eligibility, claim status, Health Net reference materials such as the Medi-Cal Recommended Drug List, Evidence of Coverage, county-specific Medi-Cal operations manuals, forms, and information on how to contact Health Net with questions.
Provider.healthnet.com

Health Net Community Resource Centers
Get help with insurance questions and enrollment forms. Plus, learn about health classes and many other community resources. East Los Angeles
Phone: 323-415-9120

Medicare Advantage Plans
Health Net Amber, Complete, Green, Gold Select, Healthy Heart, Jade, Ruby, Ruby Select and Sapphire
Phone: 800) 949-3022, option 1
Hearing Impaired (TTY/TDD): 711

For a full list of Health Net contacts, please refer to the Health Net section of the Molina Healthcare provider manual.

MOLINA® HEALTHCARE

Communications

Provider bulletin

How Molina stays in touch:

- Through Molina Healthcare's Provider Bulletin, the organization stays connected to our contracted providers and allows us to send key updates. Please make sure you provide accurate fax numbers to ensure that important communications from Molina reach you.
- Communications can include but are not limited to: Regulatory changes, business development, member resources and more.
- Submit contact information to your provider service representative. Please provide Molina with your email and/or fax information.
- Molina's Provider Bulletin can be found on our Molina website and through Availity.

MOLINA® HEALTHCARE

Provider directory

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Provider online directory

- Our goal is to ensure members have access to a highly accurate list of available providers through searchable online directories and printed directories.
- The provider online directory (POD) is accessible to Molina members and providers across all lines of business.
- Members and providers can now utilize the user-friendly, intuitive search capabilities of the new POD to find the right health care that they need.
- Select “Find A Doctor” at www.MolinaHealthCare.Com to quickly find a Molina provider or facility today with the new mobile-friendly POD.
- Report changes on the provider directory website via the hyperlink under provider details.

MOLINA HEALTHCARE

State Legislation Senate Bill 137 (SB 137)

- SB 137 requires health plans to comply with the following requirements:
  - Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care (DMHC). A willful violation of the act is a crime. Existing law requires a health care service plan to provide a list of contracting providers within a requesting enrollee's or prospective enrollee's general geographic area.
  - Publish and maintain an accurate provider directory with information on contracting providers.
  - Verify provider directory information with contracted providers on a periodic basis.
  - Update the provider online directory weekly and printed directory quarterly.
  - Ensure contracted providers notify the health plan when they are accepting new patients or no longer accepting new patients.
  - Failure to respond to the notification may result in a delay of payment or reimbursement of a claim.

Encounter data

MOLINA HEALTHCARE

Encounter data

- Encounter reporting and policy
  - MHC requires all providers/practitioners and delegated entities to submit encounter data reflecting the care and services provided to our members.

    This policy applies to all primary care practitioners (PCPs), contracted either directly with MHC or through an IPA/medical group and delegated entities required to submit encounters. It is important to note the encounter data must also reflect services provided by any ancillary personnel that are under the direction of the PCP, including any physicians (specialists) providing care and services to our patients as defined in their contract with MHC.

    The collection of encounter data is vital to Molina Healthcare of California (MHC). Encounter data provides the plan with information regarding all services provided to our membership.

    Encounter data serves several critical needs. It provides:

    - Information on the utilization of services
    - Information for use in HEDIS studies
    - Information that fulfills state reporting requirements

Encounter data

- HIPAA standards for electronic transactions
  - HIPAA requires the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. All covered entities must be in compliance with the electronic transactions and code set standards by October 16, 2003.

    Covered entities include:
    - Health plans
    - Health care providers who transmit health information in electronic form, in connection with a transaction covered by HIPAA
    - Health care clearinghouses
- Electronic health care transactions covered under HIPAA that may affect provider organizations are:

Transaction description	HIPAA transaction standard
Claims or encounter information	ASC X12N 837: Professional, or institutional health care claims or encounter ((005010X222A1/005010X223A2/005010X224A2))
Eligibility for a health plan	ASC X12N 270/271: Health care eligibility benefit inquiry and response (005010X279A1
Referral certification and authorization	ASC X12N 278: Health care services request for review and response (005010X217E2)
Claims status	ASC X12N 276/277: Health care claim status request and response ((005010X212E2)
Payment and remittance advice	ASC X12N 835: Health care claim payment/advice (005010X221A1)

Availity Provider Portal

MOLINA® HEALTHCARE

Availity Provider Portal

Availity Essentials is Molina Healthcare's official secure provider portal for traditional (non-atypical) providers. Some of the core features available in Essentials for Molina Healthcare include eligibility & and benefits, attachments, claim status, Smart claims, and Payer Space (submit and check prior authorizations as well as appeal status and appeal/dispute).

If your organization is not yet registered for Availity Essentials and you're responsible for the registration, please register at the Availity Essentials portal:
https://provider.molinahealthcare.com/

For registration issues, call Availity Client Services at (800) AVAILITY (282-4548)
Assistance is available Monday to Friday, 8 a.m. - 8 p.m. ET.

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Availity Essentials Provider Portal

Claims Corrections

- Molina providers now have access to a new claims correction feature from the claim status page. Claims Correction allows you to correct and resubmit a paid or denied claim from the claim status response page.

Overpayments

- Eliminate mail and fax for faster dispute resolution and ensure overpayment requests are up to date. View the status and details of any claim Molina has identified as an overpayment. Request additional information, dispute, or resolve the overpayment.

Patient Search

- Save time entering patient information for eligibility and benefits inquiries. Enter the patient's member ID or last name, first name, and DOB, and select the patient matching the criteria. The information will automatically populate on the request.

Molina Medicare Nov Included Molina Healthcare Payer Option

- Select only one option in the payer field. The Molina Medicare option no longer displays in the payer field. When you select the Molina Healthcare option for the region, the plan coverage for the member includes Dual-Eligible, Marketplace, Medicare, and Medicaid.

MOLINA® HEALTHCARE

Prior authorization and utilization management

Covered & carved out services

MOLINA HEALTHCARE

Prior authorization code guide

Clinical guidelines/based on practice guidelines are used for PA

- Molina requires a prior authorization for specified services as long as the requirement complies with federal or state regulations and the Molina hospital or Provider Services agreement.
- The Molina prior authorization matrix of codes that require prior auth is customarily updated quarterly, but may be updated more frequently as appropriate, and is posted on the Molina website at: https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx
- For additional information regarding the prior authorization of specialized clinical services, please refer to the prior authorization tools located on the MolinaHealthcare.com website: Prior Authorization Code Look-up Tool, Prior Authorization Code Matrix, Prior Authorization Guide

PA code guide is updated annually and is subject to change as needed

MOLINA® HEALTHCARE

Requesting prior authorization

Availity Essentials Portal:

- Participating providers are encouraged to use the Molina Availity Essentials Portal for prior authorization submissions whenever possible.
- The benefits of submitting your prior authorization request through the Availity Essentials Portal are:
  - Create and submit prior authorization requests
  - Check status of authorization requests
  - Receive notification of change in status of authorization requests
  - Attach medical documentation required for timely medical review and decision making

Fax:

- The prior authorization request form can be faxed to Molina at: (800) 811-4804.

Phone:

- Prior authorizations can be initiated by contacting Molina's Health Care Services department at: (844) 557-8434.
- It may be necessary to submit additional documentation before the authorization can be processed.

MOLINA® HEALTHCARE

Carved out services

- The pharmacy benefit has been carved out to Medi-calRx.
- Dental screening is carved out to Denti-Cal.
- Substance use disorder (SUD) treatment is carved out to the county.

For more information on the Medi-Cal Rx program and portal go to, https://medicalrx.dhcs.ca.gov/

Please refer to the Molina Provider Manual for additional information.

MOLINA® HEALTHCARE

Authorization contacts

Service area	Phone	Fax	Service Area	Phone	Fax
Prior authorization	(844) 557-8434	(800) 811-4804	Pharmacy authorizations	(855) 322-4075	(866) 508-6445
Member service benefits/eligibility	(888) 858-2150		Provider Services	(888) 858-2150	(562) 499-0619
Behavioral health	(844) 557-8434	(800) 811-4804	Dental	(877) 433-6825	(949)830-1655
Radiology authorizations	(855) 714-2415	(877) 731-7218	Transportation	(855) 322-4075	
Transplant authorizations	(855) 714-2415	(877) 813-1206	Vision	(800) 877-7195 (VSP) www.vsp.com/advantage	

Nurse Advice Line (24 hours a day, 7 days a week): (888) 275-8750 (TTY: 711)

- Members who speak Spanish can press 1 at the IVR prompt; the nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking
- No referral or prior authorization is needed.

Providers may utilize Molina Healthcare's website at:

https://provider.molinahealthcare.com/Provider/Login

- Available features include:
  - Authorization submission and status
  - Download frequently used forms
  - Provider directory
  - Nurse Advice Line report
  - Claims submission and member eligibility status

MOLINA® HEALTHCARE

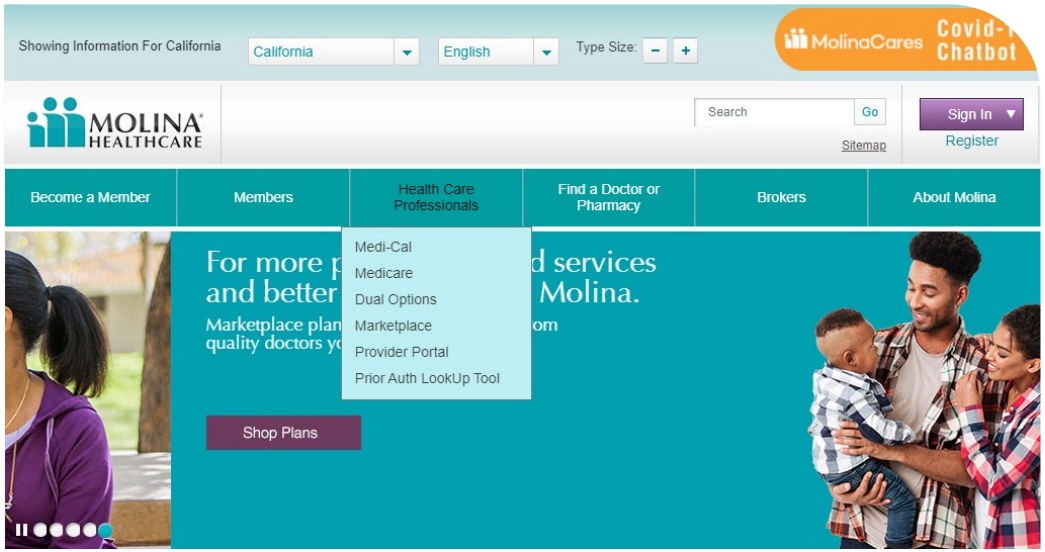
Prior Authorization Lookup Tool

Provider access

- Providers will start at: www.molinahealthcare.com
- Choose your state from the drop down

Hover over **"Health Care Professionals"** and select **"Prior Auth Look Up Tool"** from the drop-down menu for quick access to the tool.

Choose your line of business (LOB)



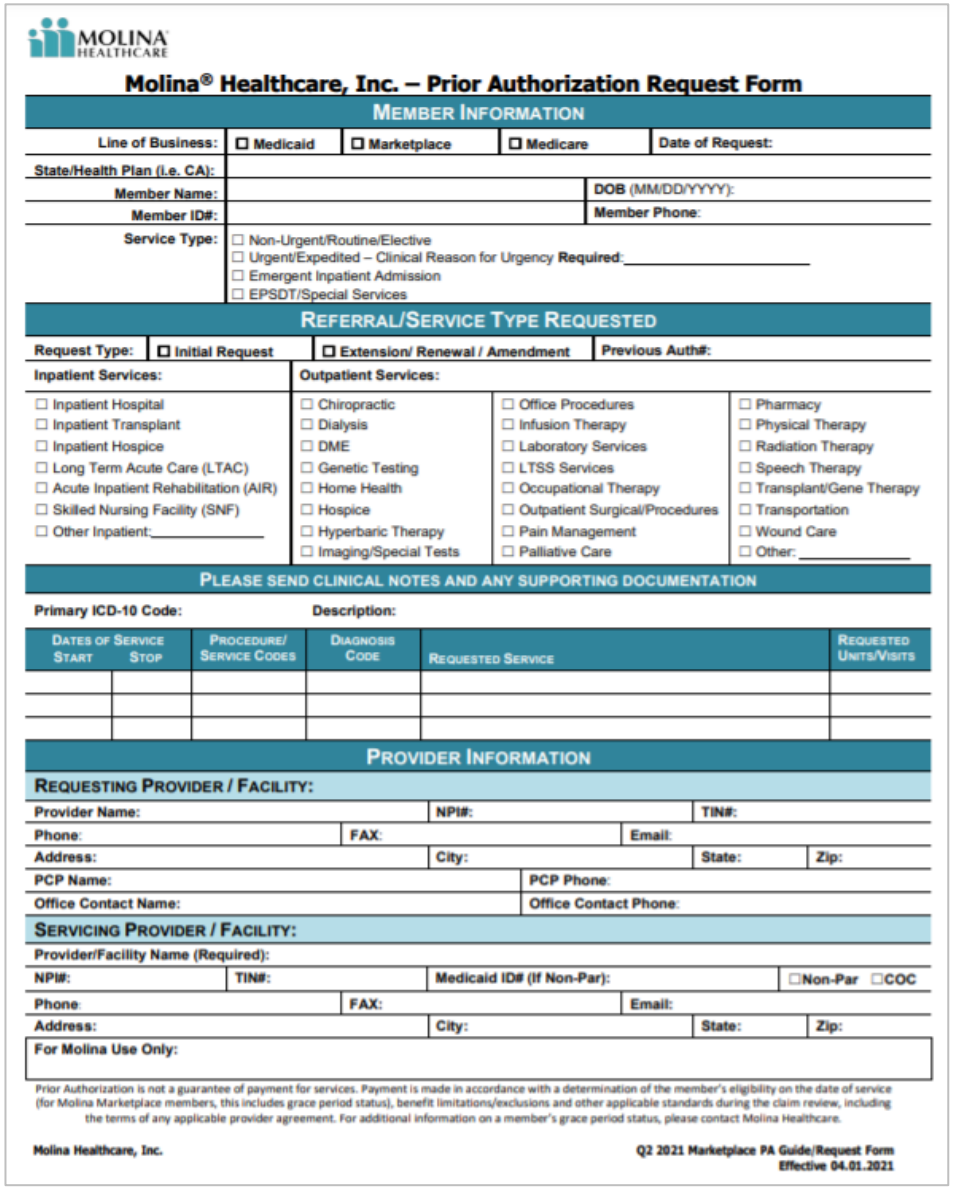
Need a Prior Authorization?

Code LookUp Tool

MOLINA HEALTHCARE

Prior authorization forms

Standard request form



MOLINA HEALTHCARE

Molina® Healthcare, Inc. – Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	☐ Medicaid	☐ Marketplace	☐ Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:			DOB (MM/DD/YYYY):	
Member ID#:			Member Phone:	

Service Type:
- ☐ Non-Urgent/Routine/Elective
- ☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____
- ☐ Emergent Inpatient Admission
- ☐ EPSDT/Special Services

REFERRAL/SERVICE TYPE REQUESTED

Request Type: ☐ Initial Request ☐ Extension/ Renewal / Amendment Previous Auth#:

Inpatient Services:	Outpatient Services:		
☐ Inpatient Hospital	☐ Chiropractic	☐ Office Procedures	☐ Pharmacy
☐ Inpatient Transplant	☐ Dialysis	☐ Infusion Therapy	☐ Physical Therapy
☐ Inpatient Hospice	☐ DME	☐ Laboratory Services	☐ Radiation Therapy
☐ Long Term Acute Care (LTAC)	☐ Genetic Testing	☐ LTSS Services	☐ Speech Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health	☐ Occupational Therapy	☐ Transplant/Gene Therapy
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Outpatient Surgical/Procedures	☐ Transportation
☐ Other Inpatient:_____	☐ Hyperbaric Therapy	☐ Pain Management	☐ Wound Care
	☐ Imaging/Special Tests	☐ Palliative Care	☐ Other:_____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: Description:

Dates of Service Start	Dates of Service Stop	Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY:

Provider Name:		NPI#:		TIN#:
Phone:	FAX:		Email:	
Address:		City:	State:	Zip:
PCP Name:		PCP Phone:		
Office Contact Name:		Office Contact Phone:		

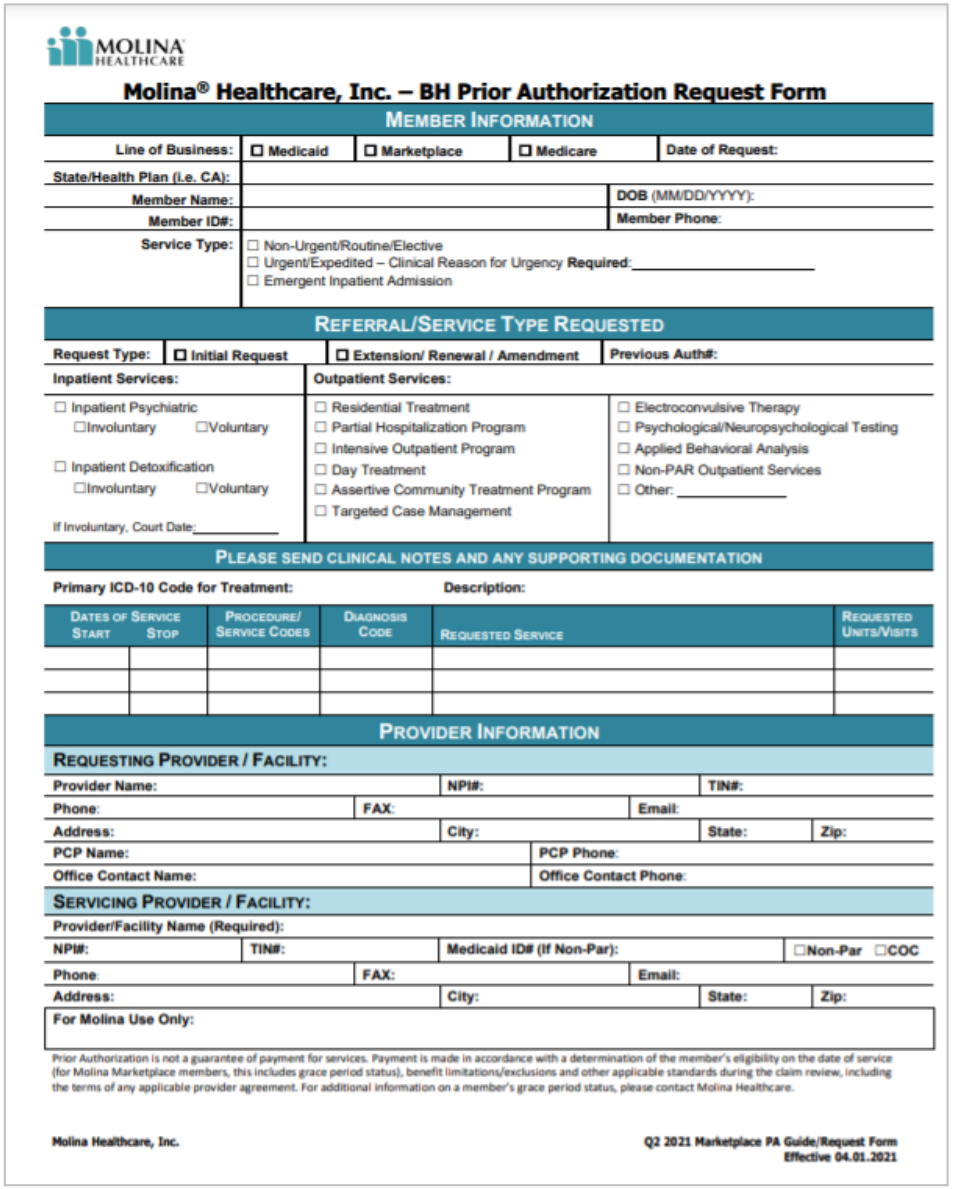
SERVICING PROVIDER / FACILITY:

Provider/Facility Name (Required):				
NPI#:	TIN#:	Medicaid ID# (If Non-Par):	☐Non-Par	☐COC
Phone:	FAX:	Email:		
Address:	City:	State:	Zip:	
For Molina Use Only:				

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service (for Molina Marketplace members, this includes grace period status), benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement. For additional information on a member's grace period status, please contact Molina Healthcare.

Molina Healthcare, Inc. Q2 2021 Marketplace PA Guide/Request Form Effective 04.01.2021

Behavioral health request form



MOLINA HEALTHCARE

Molina® Healthcare, Inc. – BH Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	☐ Medicaid	☐ Marketplace	☐ Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:			DOB (MM/DD/YYYY):	
Member ID#:			Member Phone:	

Service Type:
- ☐ Non-Urgent/Routine/Elective
- ☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____
- ☐ Emergent Inpatient Admission

REFERRAL/SERVICE TYPE REQUESTED

Request Type: ☐ Initial Request ☐ Extension/ Renewal / Amendment Previous Auth#:

Inpatient Services:	Outpatient Services:	
☐ Inpatient Psychiatric	☐ Residential Treatment	☐ Electroconvulsive Therapy
☐Involuntary ☐Voluntary	☐ Partial Hospitalization Program	☐ Psychological/Neuropsychological Testing
☐ Inpatient Detoxification	☐ Intensive Outpatient Program	☐ Applied Behavioral Analysis
☐Involuntary ☐Voluntary	☐ Day Treatment	☐ Non-PAR Outpatient Services
	☐ Assertive Community Treatment Program	☐ Other:_____
If Involuntary, Court Date:_____	☐ Targeted Case Management	

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment: Description:

Dates of Service Start	Dates of Service Stop	Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY:

Provider Name:		NPI#:		TIN#:
Phone:	FAX:		Email:	
Address:		City:	State:	Zip:
PCP Name:		PCP Phone:		
Office Contact Name:		Office Contact Phone:		

SERVICING PROVIDER / FACILITY:

Provider/Facility Name (Required):				
NPI#:	TIN#:	Medicaid ID# (If Non-Par):	☐Non-Par	☐COC
Phone:	FAX:	Email:		
Address:	City:	State:	Zip:	
For Molina Use Only:				

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service (for Molina Marketplace members, this includes grace period status), benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement. For additional information on a member's grace period status, please contact Molina Healthcare.

Molina Healthcare, Inc. Q2 2021 Marketplace PA Guide/Request Form Effective 04.01.2021

MOLINA HEALTHCARE

Utilization management

Utilization management

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

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

Utilization management

Medical necessity

“Medically necessary” or “medical necessity” is defined under Title 22, California Code of Regulations, Section 51303(a) as “health care services …which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury...” In any of those circumstances, if a patient’s condition produces debilitating symptoms or side effects, then it is also considered medically necessary to treat those.

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 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**.** To learn more about MCG or cite for guideline transparency, visit MCG's website or call (888) 464-4746.

Utilization management

UM Decisions

A decision is any determination 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)
- Discontinuation of a payment or authorization for a service

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.

Providers can contact Molina's Healthcare Services department at: (844) 557-8434 to obtain Molina's UM criteria.

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

Utilization management

Peer to peer

Upon receipt of an adverse determination, the provider (peer) may request a peer-to-peer discussion within five business days of the decision. When at all possible, the Molina medical director who made the initial denial decision will be available to discuss the case with the provider.

A “peer” is a physician, physician assistant, or nurse practitioner who provides care directly to the member. Contracted external parties, administrators, or facility UM staff can request that a peer-to-peer telephone communication be arranged and performed. However, in general, they are not the typical “peer” with whom Molina’s medical director discusses a case.

How to request a peer to peer (P2P): Call 866-814-2221 (Monday to Friday, 8 a.m. – 5 p.m.)

When requesting a peer to peer, please include the following:

- Member name
- Auth number
- Dates of Service for P2P
- Facility name
- Requesting provider name, contact number and best time to call M Decisions

Utilization management

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

Molina's UM program maintains flexibility to adapt to changes in the member's condition and is designed to influence member's care

For more information about Molina's UM program, or to obtain a copy of the HCS program description, clinical criteria used for decision making, and how to contact a UM reviewer, access the Molina website or contact the Molina's Services department at (844) 557-8434.

MOLINA® HEALTHCARE

Key functions of the UM program

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
- Pre-admission, admission and inpatient review
- Referrals for discharge planning and care transitions
- Staff education on consistent application of UM functions

Quality management

- Satisfaction evaluation 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

Claims and compensation

Claims – processing standards

Claims submission options:

1. Submit claims directly to Molina Healthcare of California.
2. Claims must be submitted by provider to Molina within 90 calendar days after the discharge for inpatient services or the date of service for outpatient services.
3. Clearinghouse (Change Healthcare).
   - Change Healthcare is an outside vendor that is used by Molina Healthcare of California.
   - When submitting fee-for-service EDI Claims (via a clearinghouse) or to Molina Healthcare of California, please utilize the following payer ID 38333.
   - EDI or electronic claims get processed faster than paper claims.
   - Providers can use any clearinghouse of their choosing. Note that fees may apply.

Electronic claims submission:

Register to access our online services with Availity. This will provide you with access to the following:

- Submit professional (CMS1500) and institutional (CMS-1450 [UB04]) claims with attached files.
- Add attachments to previously submitted claims
- Submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim
- Ability to save incomplete/un-submitted claims
- Create/manage claim templates

If you experience any problems with the Provider Portal, please contact Molina Healthcare's Help Desk at (866) 449-6848 for technical assistance or call your Provider Services representative directly.

MOLINA® HEALTHCARE

Claims – quick reference

EDI claims submissions:

- Please call the EDI customer service line at (866) 409-2935 and/or submit an email to: EDI.Claims@MolinaHealthCare.Com.
- Contact your respective county provider services representative.

Claims Customer Service:

- For assistance with any claims related processes or individual claims issues, please contact Claims Customer Service at (855) 322-4075.
- Less than 10 claims.
- Greater than 10 claims, contact your Provider Service representative.

Timely claim processing:

- Claims processing will be completed for contracted providers in accordance with the timeliness provisions set forth in the provider's contract.
- Unless the provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within 45 business days after receipt of clean claims.

Claims – quick reference

Electronic claim payment

- Participating providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)
- Providers who enroll in EFT payments will automatically receive ERAs as well.
- EFT/ERA services allow providers to reduce paperwork, provides searchable ERAs, and providers receive payment and ERA access faster than the paper check and RA processes.
- There is no cost to the provider for EFT enrollment, and providers are not required to be in-network to enroll.

Overpayments and incorrect payments refund requests

- If, as a result of retroactive review of claim payment, Molina determines that it has made an overpayment to a provider for services rendered to a member, it will make a claim for such overpayment.

- Providers will receive an overpayment request letter if the overpayment is identified in accordance with state and CMS guidelines. Providers will be given the option to either:
  - Submit a refund to satisfy overpayment,
  - Submit request to offset from future claim payments, or
  - Dispute overpayment findings.

Balance billing

MOLINA® HEALTHCARE

Balance billing

What is balance billing?

- Dual eligible beneficiaries (“Medi-Medis”) are individuals with both Medicare and Medi-Cal. Medicare health care providers (like doctors and hospitals) cannot bill dual eligible beneficiaries for Medicare cost sharing. This is known as balance billing and is illegal under both federal and state law1 . Similarly, this protection also applies to Qualified Medicare Beneficiaries (QMBs).

- Billing dual eligible beneficiaries violates Federal law as outlined in section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997. This section of the Act is available at: http://www.ssa.gov/OP_Home/ssact/title19/1902.htm Protections are also found in California Welfare and Institutions Code section 14019.4.

MOLINA HEALTHCARE

Balance billing

Examples

- Dual eligible beneficiaries or QMBs should never receive a bill for their medical services. Patients should not pay for the following:
- Physician visits and other medical care when they receive covered services from a provider in their provider network.
  - Copays
  - Co-insurance
  - Deductibles
- This applies to both Medicare and Medi-Cal providers.

Exceptions

- Dual eligible beneficiaries may receive a bill for medical services if they have a:

1. Copay for prescription drugs;
2. Monthly share of cost for Medi-Cal; and/or
3. Dental, vision, or hearing aid related service (or other benefit not covered by Medicare Part A or Part B) that is not covered by their Medicare Advantage plan, and not provided by a Medi-Cal enrolled provider

Provider disputes and resolution process

Provider disputes

- **A Provider Dispute is defined as a written notice prepared by a provider that:**
  - Challenges, appeals, or requests for reconsideration of a claim that has been denied, adjusted, or contested
  - Challenges MHC's request for reimbursement for an overpayment of a claim
  - Seeks resolution of a billing determination or other contractual dispute
- For claims with dates of service in 2004 or after, all provider disputes require the submission of a Provider Dispute Resolution Request Form or a Letter of Explanation, which serves as a written first-level appeal by the provider.
- For paper submissions, MHC will acknowledge the receipt of the dispute within 15 working days and within two working days for electronic submissions.
- If additional information is needed from the provider, MHC has 45 working days to request necessary additional information. Once notified in writing, the provider has 30 working days to submit additional information, or the claim dispute will be closed by MHC.
- **How to Submit Provider Disputes:**
  - **Method 1**: Molina Availity Essentials portal (most preferred method):
    - Log onto the Availity Essentials portal: provider.MolinaHealthcare.com
    - Search and identify adjudicated claims and submit a dispute/appeal
    - Complete the required information on the portal and upload the required documents or proof to support the dispute
  - **Method 2**: Fax to **(562) 499-0633**
  - **Method 3**: **Mail to:** Molina Healthcare of California
    Attn: Provider Dispute Resolution Unit
    P.O. Box 22722
    Long Beach, CA 90801

MOLINA® HEALTHCARE

Services for seniors and people with disabilities

MOLINA® HEALTHCARE

Developmental disability services (DDS)

Developmental disabilities services are managed through the regional center for members who are either:

- Age 36 months to 18 years old, who have a developmental delay in either cognitive, communication, emotional, adaptive, physical, motor development, including vision and hearing, or a condition known to lead to developmental delay, or those in whom a significant developmental delay is suspect, or whose early health history place them at risk for delay.
- Members who are at risk of parenting a child with a developmental disability.

Who is eligible for the regional center?

- To be eligible for services, a person must have a disability that begins before the person's 18th birthday, be expected to continue indefinitely and present a substantial disability as define in Section 4512 of the California Welfare and Institution Code. Eligibility is established through diagnosis and assessment performed by the Regional Centers.
- Infants and toddlers (age 0-36 months) who are at risk of having developments disabilities or who have a developmental delay may also qualify for services. The criteria for determining the eligibility of infants and toddlers is specified in Section 95014 of the California Government Code. In addition, individuals at risk of having a child with a developmental disability may be eligible for genetic diagnosis, counseling and other prevention services. For information about these services, see Early Start.

Developmental disability services (DDS)

Determine eligibility

- Infants and toddlers from birth to age 36 months may be eligible for early intervention services through Early Start if, through documented evaluation and assessment, they meet one of the criteria listed below:
  - Have a developmental delay of at least 33% in one or more areas of either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing; or,
  - Have established risk condition of known etiology, with a high probability of resulting in delayed development; or,
  - Be considered at high risk of having a substantial developmental disability due to a combination of biomedical risk factors of which are diagnosed by qualified personnel California Government Code: Section 95014(a); California Code of Regulations: Title 17, Chapter 2, Section 52022

PCP Screening

- The PCP shall complete an intake and assessment for members aged 0-36 months with, or suspected to have a developmental disability:
- Children shall receive a complete medical evaluation to confirm the diagnosis and determine the genetic and/or non-genetic etiology. This may include, but not limited to:
  - Prenatal/perinatal history
  - Developmental history
  - Family history
  - Metabolic and chromosomal studies
  - Specialty consultations as indicated

Developmental disability services (DDS)

Referrals to the regional center

- Referrals are made directly to the intake screener of the regional center (RC).
- Submit the referral to the RC as soon as possible.
- Please include:
  - Reason for referral
  - Complete medical history and physical examination, including appropriate developmental screens.
  - Results of developmental assessments/psychological evaluation and other diagnostic tests as indicated.

Services provided by the regional center

- Some of the service and supports provided by the regional centers include:
  - Information and referral
  - Assessment and diagnosis
  - Counseling
  - Lifelong individualized planning and service coordination
  - Purchase of necessary services included in the individual program plan
  - Resource development
  - Outreach
  - Assistance in finding and using community and other resources
  - Advocacy for the protection of legal, civil and service rights
  - Early intervention services for at risk infants and their families
  - Genetic counseling
  - Family support
  - Planning, placement, and monitoring for 24-hour out-of-home care
  - Training and education opportunities for individuals and families
  - Community education about developmental disabilities

Clinical protocols and practice guidelines for seniors and persons with disabilities/chronic conditions

It is important to ensure that the Molina members we serve receive access to quality care that supports their individual health needs. Available services include:

- Transportation to medical appointments
- Coordination of medical, social and mental health services
- Complex case management
- Improved member communications utilizing alternate formats
- Detailed information on accessibility of provider offices

How to find an accessible Molina provider:
https://www.molinahealthcare.com/providers/ca/medicaid/resource/ProviderFacilityReq.aspx

Molina's 24-Hour Nurse Advice Line:
https://www.molinahealthcare.com/providers/ca/medicaid/resource/NurseAdviceLine.aspx

Population health cultural and linguistics health education

MOLINA® HEALTHCARE

Health education

Health management program and services

Program and services

- Asthma (2+ y.o)
- Diabetes (18+ y.o)
- Hypertension (18+ y.o)
- Heart failure (18+ y.o)
- Depression (18+ y.o)
- Adult weight loss management and obesity (18+ y.o)
- Nutrition consults (2+ y.o)
- Refer using the referral form:
- https://**www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx**
- Or have members call:
- 866-891-2320, ext: 751137, option 2

Smoking cessation

Refer to KICK IT CA

- For quitting smoking, vaping, and smokeless tobacco
- Counseling is available in multiple languages (English, Spanish, Korean, Vietnamese, Cantonese and Mandarin).
- NRTs covered by Molina
- 10 – days of patches available via KICK IT for qualifying members (for members 18+)
- Speak with a Quit Coach
- 800-300-8086 (English)
- 800-600-8191 (Spanish)
- Chat with a Quit Coach
- Kickitca.org/chat

Diabetes prevention program

Contract with Teladoc Health

- For members 18+
- Pending DHCS approval
- In the interim, refer to the Health Management programs as appropriate

Maternal mental health

Prenatal and postpartum care

- Use a validated screening tool (PHQ-9, EPDS)
- G8431 (positive) and G8510 (negative)* with modifier HD for Medic-Cal members.
- Refer to a network mental health provider or County MH provider.
- Molina High-Risk OB program includes:
- Risk Screening
- Clinical case management
- Member Education
- Refer: 866-891-2320
- WeConnect app – Medi-Cal (Sac, SD, Riv, SB)
- Dx of SUD, OUD, or mental behavioral health conditions.
- Refer: https://hipaa.jotform.com/213005264240137

MOLINA HEALTHCARE

Interpretation services

Interpretation Services

Telephonic Interpreters

- Available on demand, 24/7.
- Telephonic interpretation is best for most routine appointments.
- Call the Contact Center to be immediately connected to an interpreter. No appointment needed!
- Over 125 languages
- Providers can access interpreter services via Molina Member and Provider contact center.

Video Remote Interpreters

- VRI is best for more complicated appointments or when the member needs access to a sign language interpreter.
- VRI is HIPAA compliant. It can be accessed from any standard smartphone, tablet, or laptop equipped with a webcam and requires no special software.
- Appointments should be scheduled at least 2 days in advance whenever possible.
- On-demand VRI is also available as a backup.

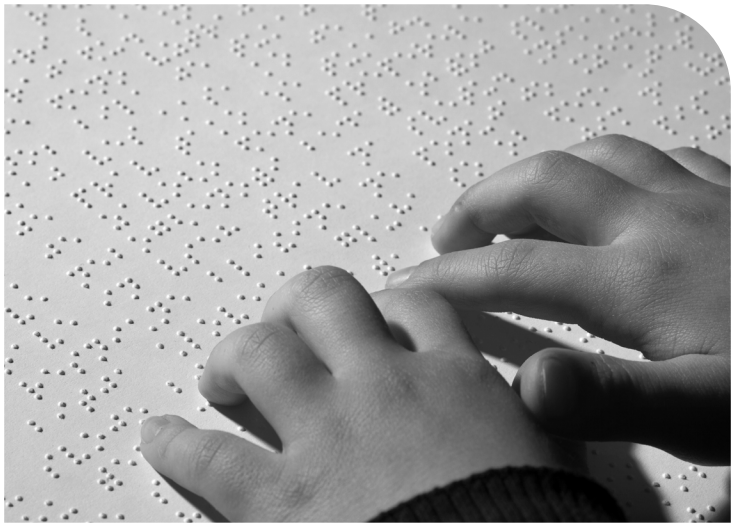
In-Person Interpreters

- In-person interpretation is used for the most complex appointments, or when VRI is not possible.
- Appointments should be scheduled at least 5 days in advance whenever possible.
- Telephonic interpretation and VRI are both available as backups in case the in-person interpretation is not approved, or the interpreter does not show

Cultural and linguistic services

Translation

- Molina translates existing health education materials, care plans, and enrollment materials into the member's preferred language upon request.
- Molina offers a variety of low literacy health education materials in English and Spanish online at: https://www.molinahealthcare.com/providers/ca/medicaid/resource/Health-Education-Materials.aspx



To access Interpretation Services:

- Call Molina's Provider Contact Center at (855) 322-4075
- For after-hours and weekends, please call Molina's Nurse Advice Line to connect to an interpreter (888) 275-8750.
- To speak to members who are deaf, hard of hearing, or have a speech difficulty, providers may use the California relay service. Dial 711 and give the relay operator (RO)/communication assistant (CA) the member's area code and telephone number.

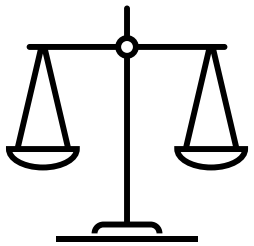
Alternate format

- Molina offers vital documents in large print, Braille, electronic files, and audio format.

MOLINA® HEALTHCARE

Cultural and linguistic training and resources

- Molina offers Cultural Competency training videos on our website: https://www.molinahealthcare.com/providers/ca/medicaid/resource/cme.aspx
- Additional resources on the Molina website include the provider education series of brochures on service members with disabilities: https://www.molinahealthcare.com/providers/ca/medicaid/resource/cme.aspx
- Molina also offers tailored training on cultural competency and sensitivity to seniors and persons with disabilities. For cultural and linguistic consultations, questions regarding cultural beliefs and practices that may affect patient care, or to request training, contact Molina: HealthEducation.MHC@molinahealthcare.com
- Molina's "Ask the Cultural and Linguistics Specialist" page is an interactive web-based question-and-answer forum on providing culturally appropriate care. All inquiries receive a response within 72 hours from Molina's Cultural Anthropologist. To access, go to our provider website: https://www.molinahealthcare.com/providers/ca/medicaid/resource/ask_cultural.aspx



Language Rights and the Law

Sections 1557 of the Affordable Care Act (ACA) requires that all limited English proficient (LEP) beneficiaries' language access needs be met for all medical appointments.

- To refuse an LEP beneficiary access to language services is a violation of that individuals civil rights.
- The ACA also prohibits providers from requesting a beneficiary to provide his or her own interpreter or rely on a staff member who is not qualified to communicate directly with the LEP individual.
- Please remember it is never permissible to ask a minor, family member, or friend to interpret.
- Molina complies with all guidance set forth in the ACA, Title VI of the Civil Rights Act, and CA SB 223, which includes instructions for accessing language services in significant member materials.

MOLINA® HEALTHCARE

Health education resources

Phone: (866) 891-2320

Monday to Friday, 8:30 a.m. - 5:30 p.m.

Fax: (800) 642-3691

Email: HealthEducation.MHC@MolinaHealthcare.com

Health education materials: https://www.molinahealthcare.com/providers/ca/medicaid/resource/Health-Education-Materials.aspx

MOLINA® HEALTHCARE

Health management programs

Health management programs

- Molina's health management programs provide patient education information to members and helps facilitate provider access to these chronic disease programs and services.
- For more information about the health management programs, please call the Provider Services department at (855) 322-4075.

Breathe with EaseSM Program

- Molina Healthcare provides an asthma health management program called breathe with ease, designed to assist Members in understanding their disease. The program educates the member and family about asthma symptom identification and control.

Building Brighter Days adult depression management program

- The Building Brighter Days depression management program is a collaborative team approach comprised of health education, clinical case management and provider education. The overall goal is to provide better overall quality of life, quality of care and better clinical outcomes for members who have a primary psychiatric diagnosis of major depressive disorder.

Health management programs

Tobacco prevention and cessation services

- All providers are required to identify and track all tobacco use, both initially and annually.
- All providers are also required to institute a tobacco user identification system to identify tobacco users in their primary care practice, per USPSTF recommendations.

Services for pregnant tobacco users

- Pregnant beneficiaries should be offered tailored, one-on-one counseling exceeding minimal advice to quit.

Prevention of tobacco use in children and adolescents

- Providers are required to: Provide interventions, including education or counseling, in an attempt to prevent initiation of tobacco use in school-aged children and adolescents.

Smoking cessation resources

https://www.molinahealthcare.com/providers/ca/medicaid/resource/smoking-cessation.aspx

Health management programs

Weight management

- Molina's weight management program is comprised of one-on-one telephonic education and coaching by a health educator to support the weight management needs of the member.
- The health education staff work closely with the member's provider to implement appropriate intervention(s) for members participating in the program.

Diabetes prevention program

- Molina Healthcare offers the diabetes prevention program (DPP) to eligible members. The DPP is an online lifestyle change program that focuses on member engagement and health outcomes and is recognized by the Centers for Disease Control and Prevention (CDC).

Health education resources

Health education materials

- Appropriate use of health care services
- Risk reduction and healthy lifestyles
- Self-care and management of health conditions

https://bit.ly/3NB3Ewj

Health education forms

- Health education referral form
- Health education services flyer

https://bit.ly/3sSWQm1

Diversity, Equity, and Inclusion

Diversity, Equity, and Inclusion training (formerly Cultural Competency)

Provider training

- Module 1: Introduction to Cultural Competency
- Module 2: Health Disparities
- Module 3: Specific Population Focus – Seniors and Persons with Disabilities
- Module 4: Specific Population Focus – LGBTQ and Immigrants/ Refugees
- Module 5: Becoming Culturally Competent
- Provider Training Attestation Form

Provider resources on gender-affirming care

- Quality Interactions
- National LGBTQIA+ Health Education Center
- San Mateo Pride.org
- LGBTQIA+/2S Collaborative
- UCSF Lesbian, Gay, Bisexual, and Transgender Resource Center

Molina provider education series

- Americans with Disability Act (ADA)
- Members who are Blind or have Low Vision
- Service Animals
- Tips for Communicating with People with Disabilities & Seniors
- Health Resources for LGBTQ+ Members

Ask Molina's Cultural and Linguistics Specialist

MOLINA® HEALTHCARE

Diversity, Equity, and Inclusion training (formerly Cultural Competency)

Building culturally competent health care: Training for health care providers and staff

1. Think cultural health (HHS Office of Minority Health)
   - A Physician's Practical Guide to Culturally Competent Care
   - Culturally Competent Nursing Care: A Cornerstone of Caring
2. Industry Collaboration Effort (ICE) Cultural Competency Training for Healthcare Providers
3. Industry Collaboration Effort (ICE) Better Communication, Better Care
4. Teach Back Method
5. Culturally and Linguistically Appropriate Service Standards
6. Americans with Disabilities Act
7. The Arc
8. Virginia Commonwealth University Life Expectancy Mapping
9. Robert Wood Johnson Foundation Life Expectancy by Zip Code

Model of Care

Model of Care (MOC)

Course overview

- The Model of Care is the plan for delivering coordinated care and care management to special needs members and provided the basic framework under which we meeting the regulatory requirements as defined by the Centers for Medicare and Medicaid Services (CMS).
- All contracted Medicare PCPs and key high-volume specialists and certain delegates are required to complete MOC training annually.
  - Key high-volume specialists: Cardiologists, Hematology & Oncology, and Psychiatry
- This training will identify how you, as a provider of care, will support the MOC, while understanding CMS requirements for managing those members.

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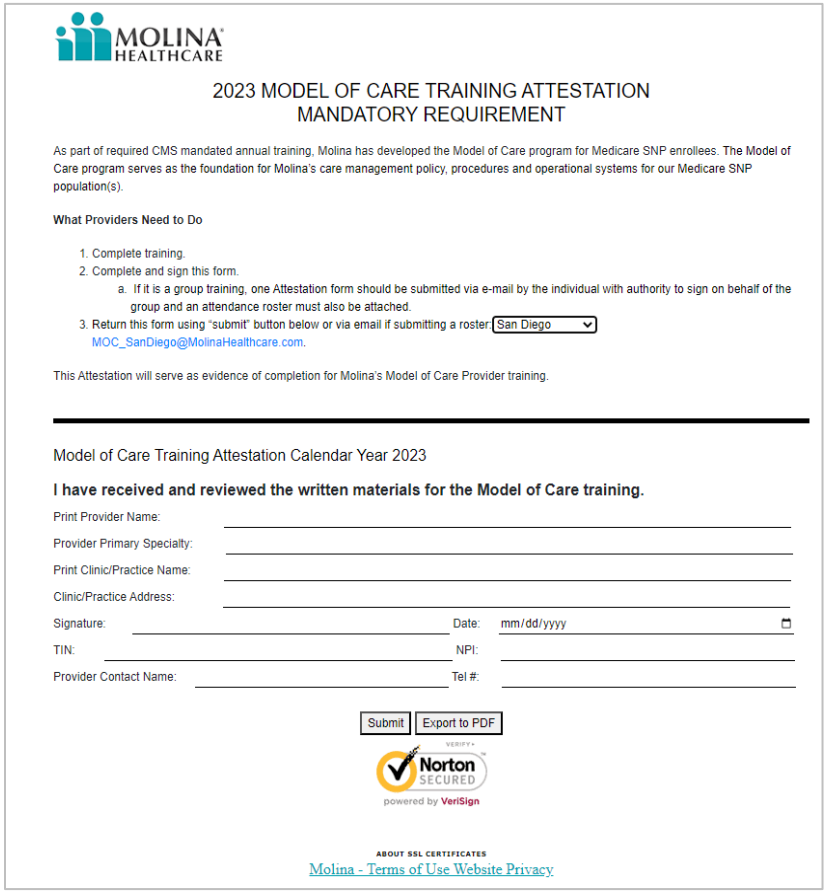
MOC – Training and attestation

Training Materials

- 2023 Model of Care Provider Training Quick Reference Guide
- 2023 Model of Care Provider Training
- 2023 Model of Care Attestation



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2023 MODEL OF CARE TRAINING ATTESTATION
MANDATORY REQUIREMENT

As part of required CMS mandated annual training, Molina has developed the Model of Care program for Medicare SNP enrollees. The Model of Care program serves as the foundation for Molina's care management policy, procedures and operational systems for our Medicare SNP population(s).

What Providers Need to Do

1. Complete training.
2. Complete and sign this form.
   a. If it is a group training, one Attestation form should be submitted via e-mail by the individual with authority to sign on behalf of the group and an attendance roster must also be attached.
3. Return this form using "submit" button below or via email if submitting a roster: San Diego
   MOC_SanDiego@MolinaHealthcare.com.

This Attestation will serve as evidence of completion for Molina's Model of Care Provider training.

Model of Care Training Attestation Calendar Year 2023

I have received and reviewed the written materials for the Model of Care training.

Print Provider Name: _____

Provider Primary Specialty: _____

Print Clinic/Practice Name: _____

Clinic/Practice Address: _____

Signature: _____ Date: mm/dd/yyyy

TIN: _____ NPI: _____

Provider Contact Name: _____ Tel #: _____

Submit | Export to PDF

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Community Supports

Purpose and Administration of Community Supports

Medi-Cal managed care plans will have the option to integrate Community Supports into their population health management plans – often in combination with the new enhanced care management benefit

Community Supports would be focused on addressing combined medical and social determinants of health needs and avoiding higher levels of care or other future health care costs

Community Supports must be cost effective. For example, Community Supports might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays and emergency department use

Molina's Community Supports

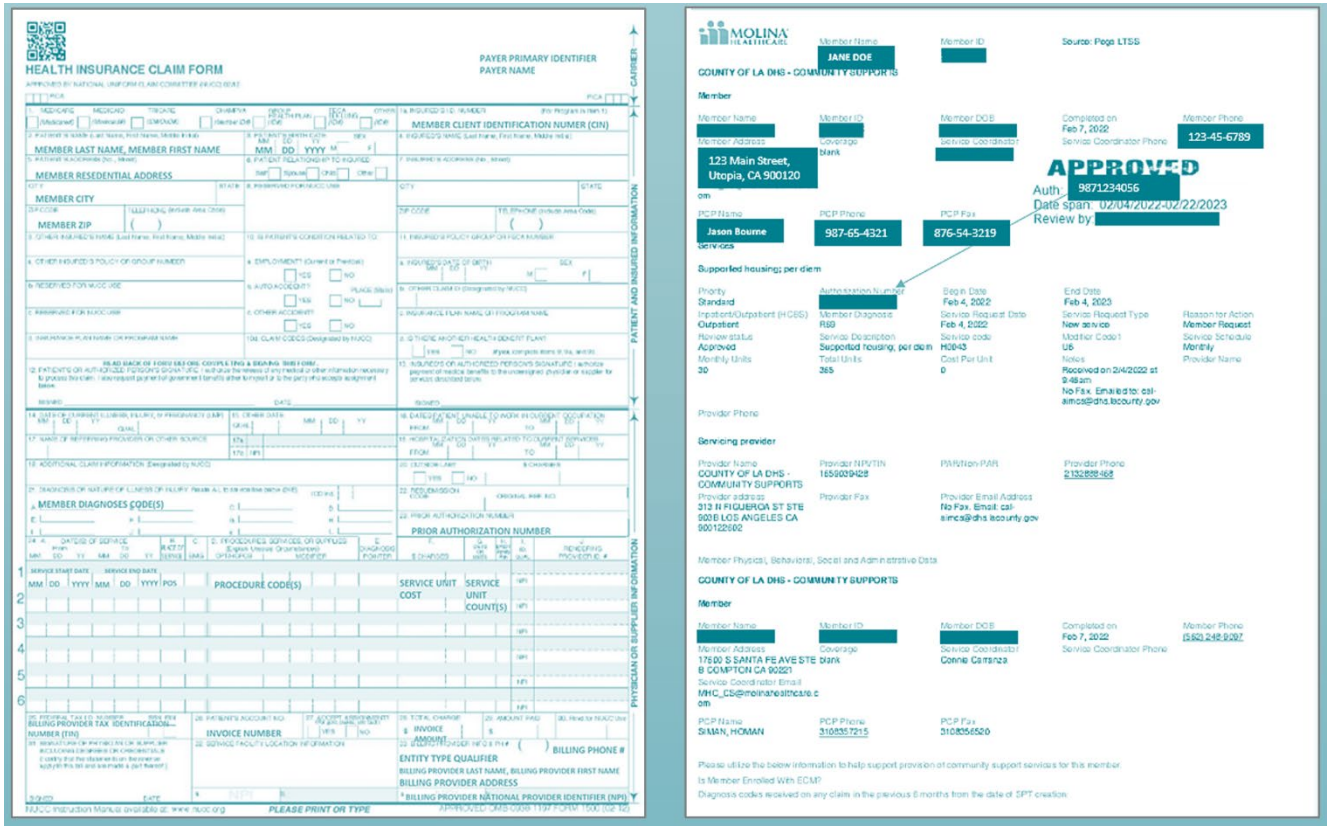
Community Supports	Imperial	Los Angeles (HN)	Riverside	Sacramento	San Bernardino	San Diego
Housing Transition Navigation Services	X	X	X	X	X	X
Housing Deposits	X	X	X	X	X	X
Housing Tenancy & Sustaining Services	X	X	X	X	X	X
Short-Term Post-Hospitalization	1/1/2024	X	X	X	X	X
Recuperative Care (Medical Respite)	1/1/2024	X	X	X	X	X
Respite Services	Home: X	Home: X	Home: X	Home: X	Home: X	Home: X
Day Habilitation Programs	X	X	X	X	X	X
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities	1/1/2024	X	X	1/1/2024	X	1/1/2024
Community Transition Services/Nursing Facility Transition to a Home	X	X	X	X	X	X
Personal Care and Homemaker Services	X	X	X	X	X	X
Environmental Accessibility Adaptations (Home Modifications)	7/1/2023	X	X	7/1/2023	X	7/1/2023
Medically Tailored Meals/Medically-Supportive Food	X	X	X	X	X	X
Sobering Centers	1/1/2024	X	X	X	7/1/2023	X
Asthma Remediation	X	X	X	X	X	X

Community Supports eligibility criteria and reminders

- Completed referrals must be submitted to the CA HCS Community Supports LTSS team for review.
- CS services require authorization (except Sobering Centers)
  - Each CS has specific qualifying criteria for members to be approved for the service. The request will be reviewed and decided by the HCS Community Supports team.
- Duplication of services is not permitted
  - Members cannot be receiving these services through another avenue, such as a state or county funded program.
- Reminders:
  - Check monthly for health plan enrollment & eligibility
  - Housing CS:
    - Housing deposits requests that include items not on the pre-approved list must be discussed.
    - ICP/Individualized housing support plan must be updated to be member-centric.
      - Provide to Molina if not using CCA
    - Quarterly CS housing assessment in CCA
  - Notify Molina for all discontinuation requests via email as soon as possible.
  - Withdrawn requests for members who not meet eligibility criteria.
    - Outreach in advance to Molina for any questions about specific CS services.

Community Supports claims

- Providers are requested to submit claims on CMS-1500.
- More information at https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.
- Please ensure that the “billing provider name” in Box 33 in your “PayTo Name {a space}{a dash}{a space}CS”. This will aid claims being linked to the correct provider contract, which has been configured.
- All claims must be submitted within 90 days of the date of service. Any corrected claims must also be submitted within 90 days of the date of service.
- Molina Healthcare of CA will accept invoices from CS provider who do not have the technical capabilities to generate a claim. However, at a minimum, CA DHCS required that provider submit information related to the minimum data elements in their invoices, which are in **colored font** on the CMS-1500 image.



Community Supports claims, cont.

- Claims codes
  - Diagnosis codes: Enter the appropriate diagnosis code(s) in box 21A-L on the CMS-1500 claim form. Enter the correspondence diagnosis pointer code indicated in box 21 A-L in box 24 E for every service line entered.
  - Place of service code: Enter the appropriate place of service code in 24 B. The place of service code list can be found in the following CMS website:
    - https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set
  - Procedure codes: Enter the procedure code that has been approved using the appropriate HCPCS code, unity and modifier, based on the description in the following table. Enter the codes in 24 D-G

Description	HCPCS Code	Units Description	Modifier To Use	Routine Authorization Timeframe*	Initial Max Units to Authorize
Housing Transition/Navigation Services: Supported housing, per month	H0043	1 unit = 1 day (monthly case rate)	U6	Initial 12 months and 6 months thereafter	365
Housing Deposits: Supported housing, per month. Requires deposit amounts to be reported on the encounter.	H0044	1 unit = 1 month	U2	6 months	6
Housing Tenancy and Sustaining Services: Support brokerage, self-directed; per month	T2041	1 unit = 15 mins (monthly case rate)	U6	Initial 12 months and 6 months thereafter	35040
Short-Term Post-Hospitalization Housing: Supported housing; per month. Modifier used to differentiate Short-Term Post Hospitalization Housing from Housing Deposits.	H0044	1 unit = 1 month	U3	3 months	3
Recuperative Care: Residential care, not otherwise specified, waiver, per diem	T2033	1 unit = 1 day	U6	Monthly	30
Respite Services – Home: Respite care, in the home; per diem	S9125	1 unit = 1 hour	U6	Daily for 4 hours and dependent on need.	4
Day Habilitation Programs: Skills training and development; per 15 minutes	H2014	1 unit = 15 mins	U6	24 hours per 6 months	96
Community Transition Services/Nursing Facility Transition to a Home: Community transition, per service. Requires billed amount(s) to be reported on the encounter.	T2038	1 unit = 1 month (monthly case rate)	U5	6 months	6
Personal Care/Homemaker Services: Personal care services; services, per hour	T1019	1 unit = 15 minutes	U6	Daily for 4 hours and dependent on need.	16
Medically-Supported Food/Medically Tailored Meals: Home delivered meal	S5170	1 unit = 1 delivered meal	U6	Up to 4 weeks	56
Sobering Centers: Alcohol and/or drug services; ambulatory detoxification	H0014	1 unit = 1 day	U6	Daily	1
Asthma Remediation: Home modifications; per service	S5165	1 unit = 1 service	U5	6 months	12 (2 units per month)

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How to refer a member?

- **CS referrals:**
  - Submit referral form to MHC_CS@molinahealthcare.com
  - IE Molina HN members – Health Net's contact center
- **Referral Forms:**
  - https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx

Case management and Long-Term Services and Supports (LTSS)

Care management

- Assists members of all ages with complex needs and/or who have difficulty coordinating their care due to:
  - Multiple comorbid diagnoses & medications
  - Needing help in accessing care or Continuity of Care
  - Experiencing health and/or behavioral health crisis
  - High utilization (admissions, ED visits)
  - Barriers in accessing care
  - Non-adherence
  - Risk for Long-term care/institutionalization
  - Long Term Services and Supports (LTSS)
  - Collaboration with the Interdisciplinary Care team including the PCP

- Basic case management:
  - Provided by PCP in collaboration with Molina
  - Initial health assessment (IHA)
  - Coordination of necessary health care services

Member identification sources: member self-referral, PCP, MG, reports, internal departments, etc.

Case management

Molina provides multiple avenues for members to be referred to the plan for case management services beyond what the PCP provides, including telephone, fax, or phone.

To refer a member for complex case management:

Phone: (833) 234-1258
Fax: (562) 499-6105
Email: MHCCaseManagement@MolinaHealthcare.com
For members under 21: MHCHealthcareServicesCCS@MolinaHealthCare.com

Molina welcomes referrals from PCPs, hospital discharge planners, social workers, CCS case managers, Early Start staff, members and/or member's family/caregivers, specialty physicians, and other practitioners. CM Program and contact information is also available from Member Services, the 24-hour Nurse Advice Line, and in the Health Care Professionals sections on the Molina website.

Members appropriate for complex case management are those who have complex service needs and may include your patients with multiple medical conditions, high levels of dependence, conditions that require care from multiple specialties, and/or additional social, psychosocial, psychological, and emotional issues that exacerbate the condition, treatment regime and/or discharge plan.

Care management programs

- Case management
- Transition of Care Program (ToC)
- Major Organ Transplant (MOT)
- My Care – palliative care program
- Community Supports

Transitions of Care

- Coaches assist members when they are admitted to the hospital and through their transitions back to their homes.
- Identification includes the Molina inpatient census and admission, discharge, and transfer (ADT) feed from health information exchanges.
- Areas they assist with:
  - Following discharge orders from the hospital:
    - Closing the loop on requested services (e.g., home health, DME).
    - Medication review.
- Education of signs and symptoms and when to report worsening conditions.
- Assist and ensure timely follow-up appointment(s) after hospitalization:
  - Goal is to secure appointments within 7 days of discharge or sooner if needed to reduce avoidable hospitalizations.
- Referrals to resources to help reduce barriers related to SDOH (e.g., transitional meals, transportation, ECM/community supports).
- Assess and refer to complex case management for ongoing needs.

Major Organ Transplant (MOT)

- Dedicated case managers provide care management services for all members undergoing evaluation for MOT, all members listed for any transplant (including kidney), and one year of follow-up.
- All transplant care must be provided through a DHCS-approved Center of Excellence (COE).
- Providers requesting transplant evaluation authorization also need to submit authorization to Molina for the facility component and listing.
- Since Molina is responsible for the transplant surgery and the bulk of transplant costs, please provide MOT evaluation authorization to Molina's preferred COEs only.
- If Molina receives requests for non-preferred COEs approved by the IPA, Molina will redirect to contracted COEs.

Major Organ Transplant (MOT)

Molina Preferred Centers of Excellence

- Cedars-Sinai Medical Center
  - Bone marrow
  - Heart
  - Liver
  - Lung

Loma Linda University Medical Center
  - Bone marrow
  - Heart
  - Kidney-Pancreas
  - Liver
  - Lung

Scripps Green Hospital
  - Liver

- University of California San Diego
  - Bone marrow
  - Heart
  - Liver
  - Lung

Scripps Hospital La Jolla
  - Bone marrow

City of Hope
  - Bone marrow
- Sharp Memorial Hospital
  - Heart

My Care – palliative care program

- All ages, primarily home-based palliative care only for Medi-Cal members
  - A specialized medical care for patients living with a serious illness.
  - The goal is to improve the quality of life for both the patient and the family.
- Criteria for all diagnoses:
  - Advanced Illness.
  - Started to use ER and inpatient hospital services related to their disease.
  - Member's death within a year would not be unexpected.

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My Care – palliative care program

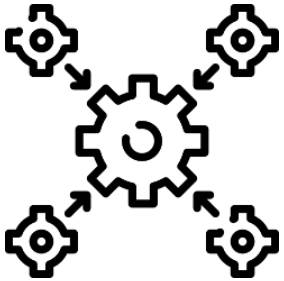
Benefits of enrollment:

- Home visits with medical team (MD, NP, nurse, MSW, chaplain): Minimum of 4 outreaches/month. At least 1 is face-to-face.
- Advanced care planning.
- Vendor's 24/7 Nurse Advice line.
- Care coordination with the treating physician and Molina (facilitate authorizations for DME, outpatient paracentesis, etc.).
- Symptoms management (pain, difficulty breathing, nausea, etc.).
- Reduce unnecessary admissions and help the member obtain the right level of care at the right time and place.
- Monthly operational meetings with vendors to review all referrals and enrolled members.

If a Molina member is identified as needing My Care services:

- Submit a referral to the palliative care vendor or
- Notify the PCP/specialist who will complete the service request form (prior auth form).
- Once approved, the palliative care vendor will reach out to the member to enroll.
- Send referrals directly to Molina preferred providers:
  - Lightbridge Hospice
  - Elizabeth Hospice

Purpose and administration of Community Supports



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DHCS menu of options: The 14 Community Supports

Housing transition Navigation services	Housing deposits (Move-In assistance)	Housing tenancy and sustaining services	Short-term post hospitalization housing
Recuperative care (Medical respite)	Respite (For caregivers)	Day habilitation programs	Nursing facility transition/diversion to assisted living facilities
Nursing facility transition to a home	Personal care and homemaker services	Environmental accessibility adaptions (home modifications)	Meal/medically tailored meals
	Sobering centers	Asthma remediation	

Long Term Services and Support (LTSS)

- Molina Medi-Cal members have access to a variety of Long-Term Services and Supports (LTSS) to help them meet their daily needs for assistance and improve their quality of life. LTSS benefits are provided over an extended period, mainly in member homes and communities, but also in facility-based settings such as nursing facilities as specified in his/her Individualized Care Plan. Overall, Molina's care team model promotes improved utilization of home and community-based services to avoid hospitalization and nursing facility care.
  - LTSS includes all of the following:
  - Community-Based Adult Services (CBAS)
  - In-Home Supportive Services (IHSS)
  - Multipurpose Senior Services Program (MSSP)
  - Long Term Care, custodial level of care in a nursing facility

To access information about how to identify LTSS needs, eligibility criteria, and how to appropriately refer for LTSS services, please refer to HEALTHCARE SERVICES: LONG-TERM SERVICES AND SUPPORTS in the Molina Healthcare Provider Manual.

Member rights and responsibilities

Member rights and responsibilities

Providers are required to comply with member rights and responsibilities as outlined in the provider manual.

Member rights include but are not limited to the following:

- Ask questions.
- If members do not agree with their provider's plan of care, they have the right to a second opinion from another provider.
- Let Molina or the state know about any fraud or wrongdoing.
- Be active in their health care.
- Entitled to confidential treatment of medical communication and records.
- Schedule appointments within the timely access standards
- Access to family planning services.
- Secure a copy of Molina's list of approved drug formulary.
- Submit a grievance.
- Decide in advance how you want to be cared for in case you have a life-threatening illness or injury.
- Get interpreter services on a twenty-four (24) hour basis at no cost to you. This service will help you to talk with your doctor or Molina if you prefer to speak a language other than English

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Timely access requirements

DHCS access and availability standards

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 OB/GYN (high-volume specialists), hematology/oncologist (high-impact specialists), and behavioral health providers. Providers are required to conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on ninety percent 80 percent availability for emergency services and 80 percent or greater for all other services (these goals may vary by plan). The PCP or their designee must be available 24 hours a day, seven days a week to members.

Appointments with the primary care practitioner (PCP)

Members are instructed through their member handbook to call their PCP to schedule appointments for routine/non-urgent care, preventive care and urgent/emergency care visits. The PCP is expected to ensure timely access to MHC members. If the need for specialty care arises, the PCP is responsible for coordinating all services that fall out of the scope of the PCP's practice.

Appointment access

All providers who oversee the member's health care are responsible for providing the following appointments to Molina members within the noted timeframes. Molina will implement corrective actions for access to health care services that do not meet the performance standards.

Interpreter services

Cultural & linguistic resources:

Member resources available in (English | Spanish | Arabic)

Provider resources available in (English)

Language Rights and the Law

- Sections 1557 of the Affordable Care Act (ACA) requires that all limited English proficient (LEP) beneficiaries' language access need be met for all medical appointments.
- To refuse an LEP beneficiary access to language services a violation of that individuals civil rights.
- The ACA also prohibits provider requesting a beneficiary to provider his or her own interpreter or rely on a staff member who is no qualified to communicate directly with the LEP individual.
- Please remember it is never permissible to ask a minor, family member, or friend to interpret.
- Molina complies with all guidance set forth in the ACA, Title VI of the Civil Rights Act, and CA SB 223, which includes instructions for accessing language services in significant member materials.

Access and availability standards

Access Measures	Access Measures Standards
Timeliness of physician office telephone answer	Within < 45 seconds of the call
Timeliness of physician office response	Within same business day of the call
Appointment Access Type	**Appointment Access Standards**
PCP – Urgent Care not requiring prior authorization	Within < 48 hours of the request
PCP – Urgent Care requiring prior authorization	Within < 96 business days of the request
PCP – Routine/Non-Urgent Care	Within < 10 business days of the request
PCP – Well-Child Preventive Care	Within < 7 business days of the request
PCP – Adult Preventive Care	Within < 20 business days of the request
Non-urgent with a non-physician behavioral health care provider	Within < 10 business days of the request
PCP – Advance Access (same or next business day appointments from the time an appointment is requested)	Not applicable: monitoring purpose only without required standard
PCP – Office Wait Time	Within < 30 minutes from appointment time
Specialist – Urgent Care not requiring prior authorization	Within < 48 hours of the request
Specialist – Urgent Care requiring prior authorization	Within < 96 business days of the request
Specialist – Routine/Non-urgent Care	Within < 15 business days of the request

Access and availability standards

Behavioral Healthcare/Substance Use Disorder Provider Appointment Access Type	BH/SUD Appointment Access Standards
BH – Urgent Care	Within < 48 hours of the request
BH – Urgent Care requiring prior authorization	Within < 96 hours of the request
BH – Routine/Non-Urgent Care	Within < 10 business days of the request
BH – Non-life-threatening emergency	Within < 6 hours of the request
BH –Routine Follow Up	Within ≤ 30 business days from the initial appointment with Prescribers (i.e.,Psychiatrist) for a specific condition
BH –Routine Follow Up	Within ≤ 20 business days from the initial appointment with Non-Prescribers (i.e.,Psychologist) for a specific condition
After-hour Availability	**After-hour Access Standards**
Appropriate after-hour emergency instruction	If this is a life-threatening emergency, please hang up and dial 911
Timely physician/network provider response to after hour phone calls/pages	Within < 30 minutes
Ancillary Access Type	**Ancillary Access Standards**
Non-urgent appointment for ancillary services	Within < 15 business days

Pharmacy

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Pharmacy benefit management (PBM): Medi-Cal

- Prescription drugs are covered by Molina Healthcare through the Medi-Cal Pharmacy Benefit carve-out to Medi-Cal Rx (MRx)

- Drug list information, including the following, can be found online:
  - Physician administered drug list
  - Drug formulary
  - Medication prior authorization criteria
  - https://medi-calrx.dhcs.ca.gov/provider/drug-lookup

Pharmacy benefit management (PBM): Medicare and Marketplace

- Prescription drugs for Medicare and Marketplace lines of business are covered by Molina Healthcare through the CVS Caremark Pharmacy Network.
- A list of in-network pharmacies are available on the www.MolinaHealthcare.com website, or by contacting Molina at (855) 322-4075.
- Drug list information, including the following, can be found online:
  - Physician administered drug list
  - Drug formulary
  - Medication prior authorization criteria
  - https://www.molinamarketplace.com/marketplace/ca/en-us/Providers/Drug-List

Provider rights and responsibilities

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Provider responsibilities and information

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

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

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

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

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Credentialing

Credentialing

All providers need to be credentialed and entered in the Molina system prior to treating members.

- Providers should utilize the CAQH website for credentialing. https://proview.caqh.org/Login/Index?ReturnUrl=%2fPO%2fProvider%2fProviderDocuments
- Ensure attestation is current and Molina has permission to access application via CAQH. (every 120 days update provider information on CAQH)
- Please address missing document/requested information request within 5 days.
- When adding a new provider to a practice, send provider profile to MHCSanDiegoProviderServices@MolinaHealthCare.Com
- Credentialing takes 60-90 days to process
- Medi-Cal providers are required to enroll as a Medi-Cal provider through DHCS and PACE to be in the Plan network Add website resources (MHCSanDiegoProviderServices@MolinaHealthCare.Com)

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Transportation services

Transportation services

Emergency medical transportation

- Emergency transportation (ambulance), or ambulance transport services, provided through the “911” emergency response system, will be covered when medically necessary.

Non- medical transportation (NMT)

- NMT is covered for medically necessary covered services. NMT is transportation by a car, taxi, or other public or private way of getting to your medical appointment.

Non-emergency medical transportation (NEMT)

- NEMT is covered for medically necessary covered services. NEMT is transportation by ambulance, litter van, wheelchair van or air.
- A primary care physician or specialist will need to complete a provider certification statement form prior to the member receiving NEMT services. The Physician Certification Statement from can be downloaded at:

http://www.molinahealthcare.com/providers/ca/medicaid/forms/Pages/fuf.aspx

Scheduling transportation services

- Please call American Logistics Transportation at (844) 292-2688 at least three (3) business days (Monday to Friday) before the scheduled appointment

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Provider relations

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Online resources

Information at your fingertips:

As a key partner of Molina, access to the Provider Manuals and other resources are available to you via the Molina website. Molina provides a wide variety of information to answer your questions and assist in ongoing educate and compliance with state, federal, and regulatory requirements.

Please feel free to use our online resources where you can access additional information:

- Member Rights and Responsibilities
- Fraud, Waste and Abuse

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Provider relations support

- As a contracted provider with Molina, you are an essential part of delivering quality care to our members. We value our partnership and appreciate the family-like relationship that you pass on to our members.

- The role of your Provider Relations Representatives is to assist your office. Your PR is available to offer training, conduct visits to provider offices and/or virtual, help with Provider Portal registration, answer questions, and serve as the point of contact for all provider needs.

- Molina welcome's your feedback and looks forward to supporting all your efforts to provide quality care for our members.

Molina Healthcare Provider Relations

General Inbox/Demographic Updates:

MHC_LAProviderServices@MolinaHealthcare.com

Maria Guimoye, Provider Relations HP

Email: Maria.Guimoye@molinahealthcare.com

Phone: (562) 549-4390

Hayat Allam, Manager, Provider Relations HP

Email: hayat.allam@molinahealthcare.com

Phone: (562) 456-4028

Kristin Rosemond, AVP, Network Strategy and Services

Email: kristin.rosemond@molinahealthcare.com

Phone: (562) 542-1919

MOLINA® HEALTHCARE

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MOLINA HEALTHCARE

Health education resources

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MolinaHealthcare.com

Health Management Services

Provider Resources

Pregnancy Program

- To refer, complete and fax Molina's Pregnancy Notification Form to **(855) 556-1424**.
- LA County Medi-Cal members are eligible to participate in the pregnancy program offered by Health Net by calling **(800) 675-6110 (TTY: 711)**.

Smoking Cessation

Molina Healthcare collaborates with **Kick It California** to provide smoking cessation counseling.

Tobacco Cessation Services

- English: **(800) 300-8086** or Text "Quit Smoking" to **66819**
- Spanish: **(800) 600-8191** or Text "Dejar De Fumar" to **66819**
- Tobacco Chewers: **(800) 987-2908**
- Chinese: **(800) 838-8917**
- Korean: **(800) 556-5564**
- Vietnamese: **(800) 778-8440**

Vape Cessation Services

- English: Call **(844) 866-8273** or Text "Quit Vaping" to **66819**
- Spanish: Call **(800) 600-8191** or Text "No Vapear" to **66819**
- **Nicotine Replacement Therapy** - If an NRT requires a prior authorization, complete Prescription Drug Prior Authorization form and fax to **(866) 508-6445**.
- List of group counseling, support group or classes: **https://www.molinahealthcare.com/providers/ca/medicaid/resource/smoking-cessation.aspx**.

Weight Management

- To refer, complete and fax Telephonic Health Education Referral form to **(800) 642-3691**.

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Nutrition Consults by a Dietitian

To refer, complete and fax the Telephonic Health Education Referral form to **(800) 642-3691** with provider nutrition prescription and supporting lab valuies.

Health Management Programs and Services

- Asthma
- Diabetes
- Adult Depression
- Heart Health
- COPD

To refer, complete and fax the Health Education Referral form to **(800) 642-3691**.

LA County Medi-Cal members may participate in the Disease Management programs offered by Health Net by calling **(800) 675-6110 (TTY: 711)**.

The above programs are available to Medi-Cal, Medicare, Cal MediConnect (MMP) and Marketplace members.

Diabetes Prevention Program

- Medi-Cal and Marketplace members
  - Refer to website to enroll. **http://www.yeshealth.com/molina**
- LA County Medi-Cal members
  - Refer to Health Net **(800) 675-6110** (TTY: **711**)

Health Education Materials

- Appropriate use of healthcare services
- Risk reduction and healthy lifestyles
- Self care and management of health conditions

Available in other languages and large font as requested.
https://www.molinahealthcare.com/providers/ca/medicaid/resource/Health-Education-Materials.aspx.

Health Education Forms and Resources

https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx.

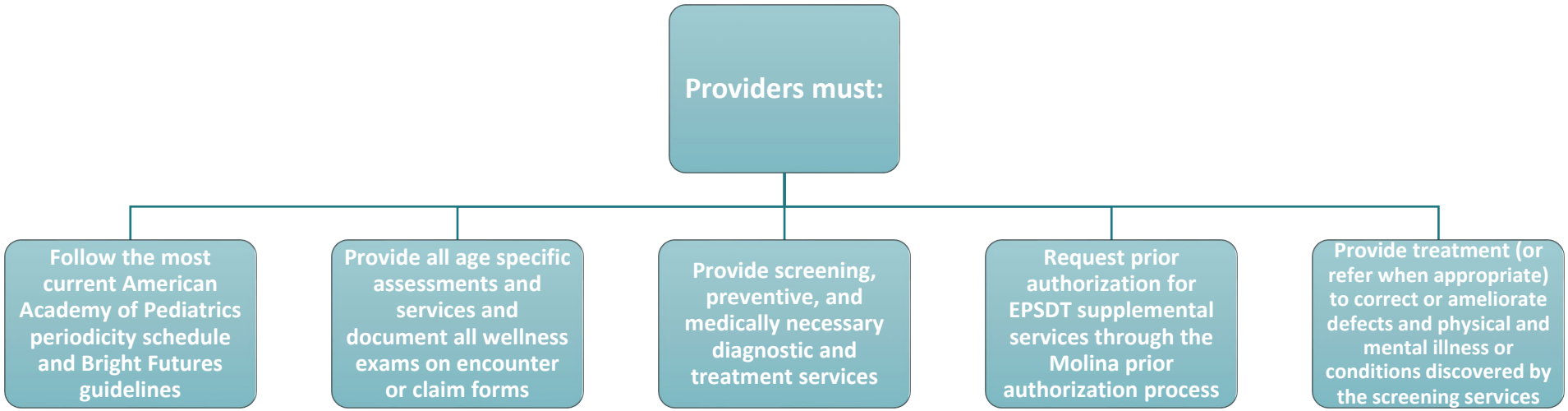
- Telephonic health education referral form
- Staying Healthy Assessment (SHA) Form (in all threshold languages)
- Staying Healthy Provider Training Video
- Staying Healthy Provider Training Attestation Sign-In Form
- Alternate IHEBA Notification Form
- SHA Electronic or Other Format Notification Form
- Prescription Drug Prior Authorization Form

MOLINA HEALTHCARE

Preventive health care services

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit

- The Early and Periodic Screening, Diagnostic and Treatment services benefit provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in full-scope Medicaid.
  - EPSDT purpose: Assure that individual children get the health care they need when they need it.
  - MHC's Role: Ensure that eligible children receive early detection and preventive care in addition to medically necessary treatment services
  - Provider's role: Avert or diagnose health problems and treat as early as possible



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Early and Periodic Screening, Diagnostic and Treatment services coverage

EPSDT Services include the following:

- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- Immunizations in accordance with the most current California and childhood immunization schedule, as appropriate
- Comprehensive unclothed physical “head-to-toe” examination
- Laboratory tests as specified by the AAP, including screening for lead poisoning
- Health education
- Vision services
- Hearing services
- Dental services
- Nutritional assessment

- States are required to provide any Medicaid-covered service listed within the categories of mandatory and optional services in the SSA Section 1905(a) to EPSDT beneficiaries, regardless of whether they are normally covered for adults under the usual Medi-Cal benefit.
- When a screening examination indicates the need for further evaluation, providers must initiate EPSDT services in a timely manner, as soon as possible but **no later than 60 calendar days** following either a preventive screening or other visit that identifies a need for follow-up.

Children's Health and Disability Prevention program

The Children's Health and Disability Prevention (CHDP) program is administered by the Children's Medical Services branch in the Systems of Care division of the Department of Health Care Services (DHCS) and is operated by local health departments.

The following Medi-Cal-enrolled providers are eligible to participate in the CHDP program as health assessment providers if they meet CHDP enrollment requirements:				
Physicians	Independent pediatric nurse practitioners	Independent family nurse practitioners	Medical groups/health clinics	Laboratory providers

CHDP/EPSDT certification is provided at no cost by the county CHDP/EPSDT program and usually involves an interview and office evaluation. Providers must apply to the local CHDP program in each jurisdiction in which they wish to render services by submitting the following forms:

- California Child Health and Disability (CHDP) Program Assessment Provider Application (DHCS 4490)
- CHDP Health Assessment Provider Program Agreement (DHCS 4491)

Non-CHDP certified physicians may contact the state directly or the MHC Provider Services Department at (855) 322-4075 for assistance to help facilitate this process.

Child Health and Disability Prevention/Early and Periodic Screening, Diagnostic, and Treatment services resources

The Molina Child Health and Disability Prevention (CHDP)/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services department handles all CHDP/EPSDT wellness services and collects data from encounter/claims submissions for CHDP/EPSDT P4P incentive payments from primary care practitioners to ensure the receipt of incentive payouts by MHC.

For more information on CHDP/EPSDT, please review the links below:

- DHCS requirements for coverage of EPSDT Services for Medi-Cal members under the age of 21, APL 23-005: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf
- Medi-Cal provider manual, chapter 13: https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ca/Medicaid/2023-Medi-Cal-Provider-Manual.pdf
- CHDP periodicity schedule: https://www.dhcs.ca.gov/services/chdp/Pages/Periodicity.aspx
- CHDP program requirements, eligibility and enrollment: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/epsdtchdp.pdf

All providers should submit timely claims and/or encounter data through normal and current reporting channels to ensure the receipt of the CHDP/EPSDT wellness services: http://www.MolinaHealthcare.com

Molina Healthcare of California
P.O. Box 16027
Mailstop “HFW”
Long Beach, CA 90806

Attn: CHDP/EPSDT department

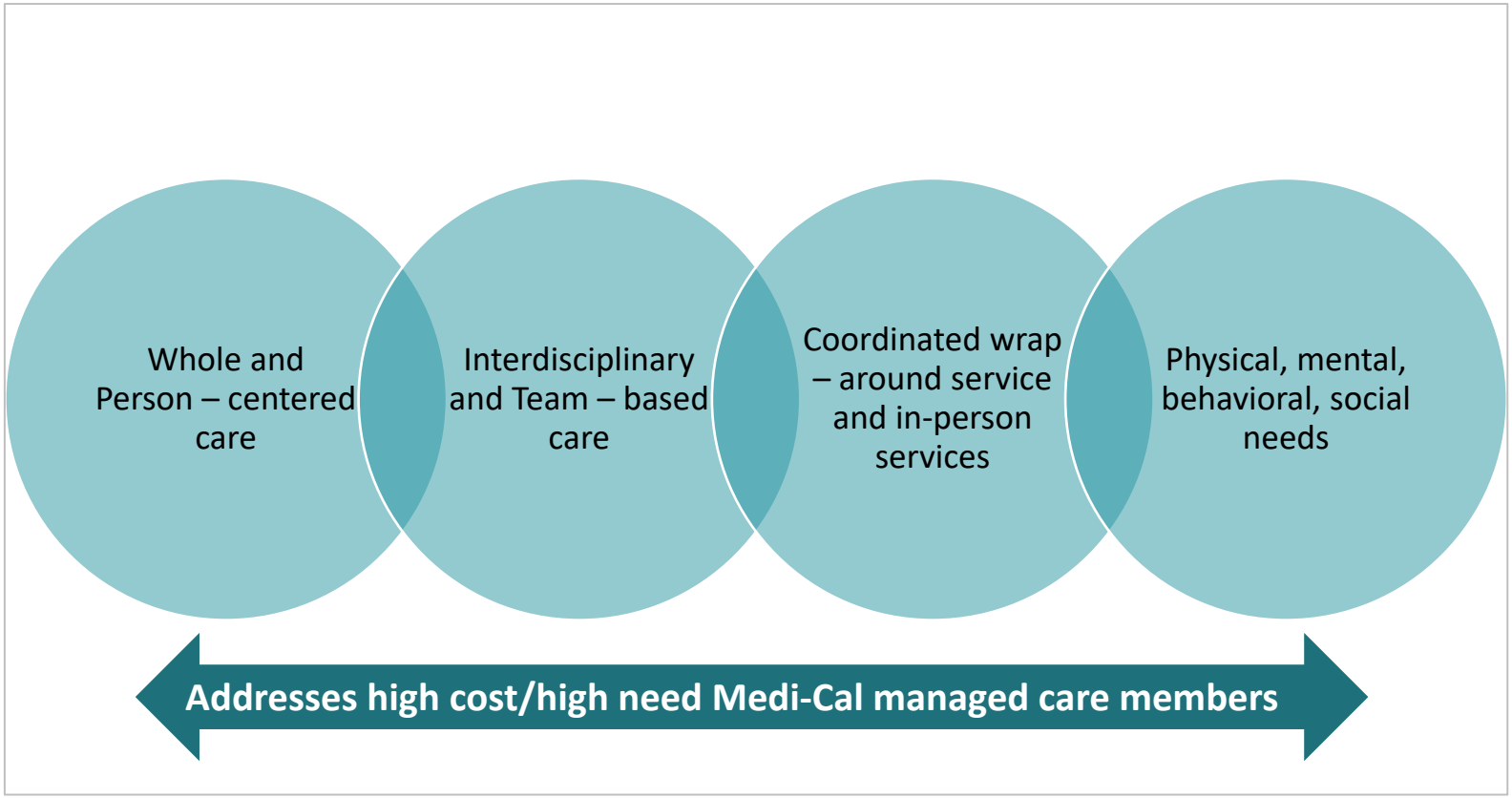
Phone: (800) 526-8196
Fax: (562) 499-6117

MOLINA® HEALTHCARE

Enhanced care management

What is ECM?

- It is a statewide enhanced care management (ECM) benefit that provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. The ECM benefit building on the current Health Homes (HH) program and Whole Person Care (WPC) Pilots.



MOLINA HEALTHCARE

ECM eligibility and exclusions

1) 1915(c) Waivers	2) Services Carved Out of Managed Care	3) Services Carved into Managed Care	4) Dual–Eligible Members	5) Other Programs	6) Programs Serving Pregnant & Postpartum Individuals
Multipurpose Senior Services Program (MSSP)	California Children's Services (CCS)	CCS Whole Child Model (WCM)	Dual Eligible Special Needs Plans (D-SNPs)	California Community Transitions (CCT) Money Follows the Person (MFTP)	Comprehensive Perinatal Services Program (CPSP)
Assisted Living Waiver (ALW)	County-Based Targeted Case Management (TCM)	Complex Care Management (CCM)	D-SNP Look-Alike Plans	Family Mosaic Project	Black Infant Health (BIH) Program
Home and Community-Based Alternatives (HCBA) Waiver	Specialty Mental Health Services (SMHS) TCM	Community-Based Adult Services (CBAS)	Other Medicare Advantage Plans	Hospice	California Perinatal Equity Initiative (PEI)
HIV/AIDS Waiver	SMHS Intensive Care Coordination for Children (ICC)		Medicare Fee For Service (FFS)	California Wraparound	American Indian Maternal Support Services (AIMSS)
HCBS Waiver for Individuals with Developmental Disabilities (I/DD)	Drug Medi-Cal Organized Delivery System (DMC-ODS) & Drug Medi-Cal (DMC) Program Care Coordination & Management Programs		Cal MediConnect		CDPH California Home Visiting Program (CHVP)
Self-Determination Program for Individuals with I/DD	Full Service Partnership (FSP)		Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)		CDSS CalWORKs Home Visiting Program (HVP)
	Health Care Program for Children in Foster Care (HCPCFC)		Program for All-Inclusive Care for the Elderly (PACE)		
	In Home Supportive Services (IHSS)				
	Genetically Handicapped Person's Program (GHPP)				

Note:

- Molina does not consider MedZed HC 2.0 & My Palliative Care Duplicative Programs. Members are allowed to be in these programs & in ECM. There two programs are considered "supportive" programs towards member's care.
- Per DHCS, Members will not be able to obtain both Molina Case Management & ECM services as that is considered duplicative.

1. ECM and the other program	MCP Members can be enrolled in both ECM and the other program. ECM enhances and/or coordinates across the case/care management available in the other program. MCP must ensure non-duplication of services between ECM and the other program.
2. Either ECM or the other program	MCP Members can be enrolled in ECM or in the other program, not in both at the same time.
3. Not Eligible to Enroll in ECM	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM.

MOLINA® HEALTHCARE

ECM populations of focus

- **January 2022**
  - Adults and their families experiencing homelessness
  - Adults at risk for avoidable hospital or emergency department (ED) utilization (formerly “high utilizers")
  - Adults with serious mental health and/or substance use disorder (SUD) needs
  - Individuals transitioning from incarceration (some WPC counties)
  - Adults with intellectual or developmental disabilities (I/DD)
  - Pregnant or postpartum adults
- **January 2023**
  - Adults living in the community and at risk for Long Term Care (LTC) institutionalization
  - Adult nursing facility residents transitioning to the community
- **July 2023**
  - Adults without dependent children/youth living with them experiencing homelessness
  - Homeless families or unaccompanied children/youth experiencing homelessness
  - Children and youth at risk for avoidable hospital or ED utilization
  - Children and youth with serious mental health and/or SUD needs
  - Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition
  - Children and youth Involved in child welfare
  - Children and youth with I/DD or pregnant or postpartum Youth
- **January 2024**
  - Birth equity population of focus
  - Individuals transitioning from incarceration (statewide, inclusive of the former WPC counties that when live in January 2022)

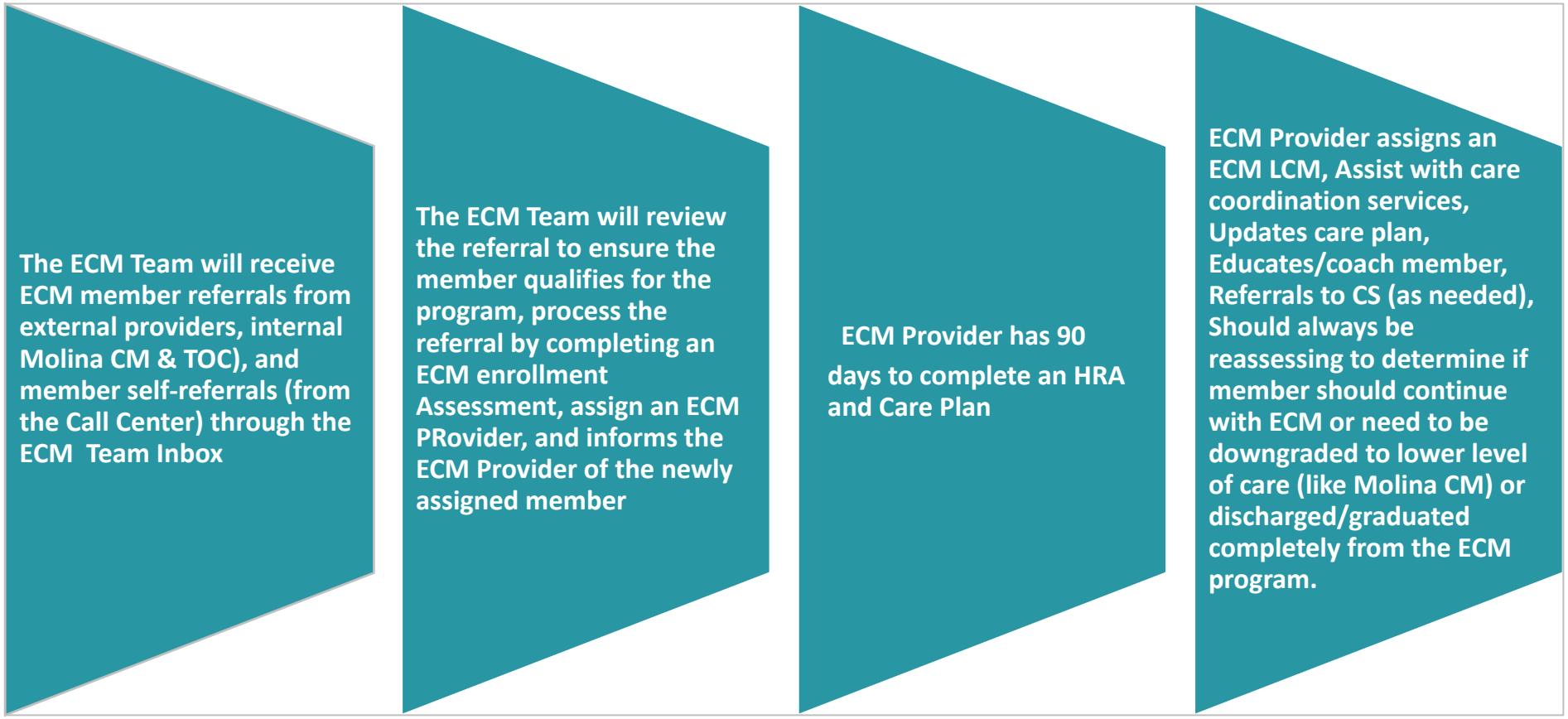
ECM’s seven core services

Outreach & Engagement	• In person, culturally & linguistically appropriate
Comprehensive Assessment & Care Plan	• Assess member strengths, risks, needs, goals, gaps in care and their preferences. Develop a comprehensive, individualized, person-centered Care Plan that coordinates and integrates all Member's clinical and non-clinical health care related needs.
Health Promotion	• Promote self-management, collaborate to identify & build on successes and resiliencies
Comprehensive Transistional Care	• Develop strategies to reduce avoidable Member admissions and readmissions
Enhanced Coordination of Care	• Ensure care continuous and integrated among all service providers
Individual and Family/Social Supports	• Identify supports needed to manage the member's condition and assist them in accessing needed support services
Coordination of & Referral to Community & Social Services	• Coordinate and refer to available community resources and follow up to ensure services were rendered - "closed loop referrals"

MOLINA® HEALTHCARE

How to refer a member

- Molina accepts county-specific referral forms. Molina's ECM referral form is on Molina's public website https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx
- Submit referral the completed referral form to - MHC_ECM@Molinahealthcare.com
- 5 business day turnaround for processing and response. If referral is more urgent, please indicate URGENT in subject line when sending – allow 2 business days but will attempt to process same day
- For IE Molina HN member, contact Health Net's member services



California Children's Service (CCS)

California Children's Services

- California Children's Services (CCS) is a state program for children with certain diseases or health problems. Through this program, children up to 21 years old can get the health care and services they need. The program arranges and pays for medical care, equipment and rehabilitation when these services are authorized by the program.
- The CCS program is administered as a partnership between county health departments and the California Department of Healthcare Services (DHCS).
- Examples of CCS eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.
- The CCS program provides diagnostic and treatment services, medical case management, physical and occupational therapy service to children under age 21 with CCS eligible medical conditions.

CCS FAQ

- Apply to become a paneled CCS provider at: https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx

- For CCS referrals, please go to: https://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4509.pdf

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Medi-Cal

- Not all hospitals are CCS paneled.
- Not all parts of the hospitals are CC paneled.
- If the patient is admitted to a non-CCS paneled hospital, CCS will not pay unless the patient is transferred to a CCS paneled hospital, or the hospital immediately notified CCS and received day to day approval to provide care until the patient can be transferred to a CCS paneled hospital.
- At least one of the physicians caring for the patient in the CCS paneled hospital must be CCS paneled.

MOLINA® HEALTHCARE

Health care and preventative care services for women and adults

MOLINA® HEALTHCARE

Health care and preventive care services for women and adults

Pregnancy and maternity care

All pregnant and postpartum women must be offered access to the Comprehensive Perinatal Services Program (CPSP) or equivalent services.

This includes the multidisciplinary integration of health education, nutrition, and psychosocial assessments. In addition, pregnant and postpartum women have access to the following:

Medical/obstetrical Care	Trimester reassessments
Genetic counseling	Postpartum assessment
Case coordination	Health education
Case management	Nutrition assessment
Individualized Care Plan (ICP)	Psychosocial assessment

Medical/obstetrical care will be provided to both the common and identified high-risk pregnancy/postpartum member within seven to 84 days postpartum.

Health care and preventive care services for women and adults

Provider/practitioner responsibilities

OB care providers/practitioners are strongly encouraged to be CPSP certified or have a formal relationship with a CPSP certified provider/practitioner for the provision of CPSP support services. All pregnant members shall be referred and assigned to CPSP certified providers/practitioners for CPSP services, whenever possible. The CPSP providers/practitioners shall be involved with the following:

- Integration of clinical health education, nutrition, and psychosocial assessment.
- Medical obstetrical care, genetic counseling, and case coordination/management.
- Use of appropriate documentation and care planning tools.
- Submission of encounter and outcomes data.

As of July 1, 2019, AB 2193 maternal mental health requires a licensed health care practitioner who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. A health provider must use a validated tool to assess the member's mental health, either in the prenatal or postpartum period, or both. Two examples are the Patient Health Questionnaire-9 (PHQ-9) and the Edinburgh Postnatal Depression Scale (EPDS).

Molina requires health care providers to document mental health screening for pregnant or postpartum members using the current CPT/HCPCS claim codes.

Health care and preventive care services for women and adults

Provider/practitioner responsibilities:

CPSP certified providers/practitioners of perinatal services	Non-CPSP certified providers/practitioners of perinatal services
• CPSP certified providers/practitioners shall be responsible for providing and complying with all CPSP service requirements for their pregnant and postpartum members up to 60 days after delivery. • CPSP certified providers/practitioners shall be responsible for complying with MHC's policy and procedure and CPSP requirements and standard including use of appropriate assessment, documentation, and care planning tools; submission of reporting forms (i.e. pregnancy notification report. • All CPSP providers/practitioners will receive information on how to obtain copies of CPSP's "Steps to Take" materials which provide helpful information to staff members to effectively assess, provide intervention for common pregnancy related conditions/ discomforts and how to appropriately refer pregnant members to all appropriate services.	• Non-CPSP providers/practitioners must comply with MHC policy and procedures and standards including: • Use of appropriate assessment, documentation, and care planning tools: ○ Submission of reporting forms (e.g., pregnancy notification report) ○ Employment of appropriate, qualified staff (e.g., CPHW) • MHC's perinatal services staff may also perform audits/reviews on, but not limited to, the following: ○ Member satisfaction questionnaire ○ Member complaints

Health care and preventive care services for women and adults

Preventive care

- MHC requires contracted providers/practitioners of perinatal services to adhere at minimum to the current American College of Obstetrics and Gynecologists (ACOG) standards, current edition.
- MHC prenatal preventive care guidelines are derived from recommendations from nationally recognized organizations, such as the ACOG, U.S. Preventive Services Task Force, the American Academy of Family Physicians, and others. They are updated annually. Prenatal preventive care guidelines are available on the MHC webpage at: MolinaHealthcare.com.
- The MHC UM department shall be responsible for reviewing all referrals and treatment authorization requests for perinatal services of MHC members where prior authorization is required. Please refer to MHC's Prior Authorization Guide in the Health care Service Section.
- MHC providers/practitioners shall follow ACOG's guidelines for perinatal care regarding the frequency of visits/reassessments: Uncomplicated pregnancy
  - Every four weeks for the first 28 weeks
  - Every two to three weeks until the 36th week
  - After the 36th week, then weekly until delivery
  - Postpartum, three to eight weeks after delivery

Health care and preventive care services for women and adults

Preventive care

Nurse midwife services:

- Defined by Title 22, nurse midwife services are permitted under state law and are covered when provided by a Certified Nurse Midwife (CNM). MHC will provide access to and reimbursement for CNM services under state law. Federal guidelines have been established and members have the right to access CNM services on a self-referral basis.

Special supplemental nutrition program for Women, Infants & Children:

- The Women, Infants & Children (WIC) supplemental food program is a local county program that is available for eligible pregnant women, infants and children under 5. This program provides an evaluation and, if appropriate, a referral for pregnant, breastfeeding, or postpartum women or parents or guardians of a child under five years of age for services. Program services include nutrition assessment and education, referral to health care, and monthly vouchers to purchase specific food needed to promote good health for low-income pregnant, breast-feeding, and postpartum women, infants, and children under five years of age with a medical/nutritional need.

Program services:

- WIC participants receive a packet of food vouchers each month, which they can redeem at the local retail market of their choice, for supplemental food such as milk, eggs, cheese, cereal, and juice. WIC participants attend monthly nutrition and health education classes and receive individual nutrition counseling from registered dieticians and nutrition program assistance. WIC also refers participants to other health and social service programs. Federal law requires the WIC program to promote and support breast-feeding.

Health care and preventive care services for women and adults

Breast-feeding promotion, education, and counseling services

Postpartum women should receive the necessary breast-feeding counseling and support immediately after delivery. Assessment of breast-feeding support needs should be part of the first newborn visit after delivery.

Durable medical equipment (DME)

- Lactation management aids, classified as DME, are covered benefits for MHC members. Specialized equipment, such as electric breast pumps, will be provided to breast-feeding MHC members when medically necessary.

Human milk bank

- Medi-Cal benefits include enteral nutritional supplemental or replacement formulas when medically diagnosed conditions preclude the full use of regular food. The provision of human milk for newborns will be arranged in the following situations:
  - Mother is unable to breastfeed due to medical reasons and the infant cannot tolerate or has medical contraindications to the use of any formula, including elemental formulas

For information regarding human milk banks, please contact your local WIC office.

Health care and preventive care services for women and adults

Adult preventive care services guidelines

MHC implements programs to encourage preventive health behaviors which can ultimately improve quality outcomes. Preventive health guidelines (PHG) are updated annually and derived from recommendations from nationally recognized organizations, such as the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians, and others. The recommended services noted in the PHG are based on clinical evidence; however, providers/practitioners and members should check with the plan to determine if a particular service is a covered benefit.

- **Preventive health guidelines:**
  - See website (www.MolinaHealthcare.com) for current and updated guidelines
- **Clinical practice guidelines:**
  - See website (www.MolinaHealthcare.com) for current and updated guidelines

Health care and preventive care services for women and adults

Initial health assessments (IHA)

The primary care physician (PCP) has the principal role to maintain and manage their assigned members. The PCP conducts the IHA and provides necessary care to members and coordinates referrals to specialists and health delivery organizations as needed. The IHA is a comprehensive assessment that is completed during the member's initial encounter with a selected or assigned PCP and must be documented in the member's medical record. The IHA enables the member's PCP to assess and manage the acute, chronic and preventive health needs of the member.

Members are required to have an IHA within 120 days of enrollment with Molina Healthcare.

The goals of the IHA are to assist providers with:

- Identifying and tracking high-risk behaviors of members.
- Prioritizing each Member's need for health education related to lifestyle, behavior, environment, and cultural and linguistic needs.
- Initiating discussion and counseling regarding high-risk behaviors.
- Providing tailored health education counseling, interventions, referral, and follow-up.

IHA services

MOLINA HEALTHCARE

Initial health assessments (IHA)

The primary care physician (PCP) has the principal role to maintain and manage their assigned members. The PCP conducts the IHA and provides necessary care to assigned members and coordinates referrals to specialists and health delivery organizations as needed. The IHA is a comprehensive assessment that is completed during the member's initial encounter with a selected or assigned PCP and must be documented in the member's medical record. The IHA enables the member's PCP to assess and manage the acute, chronic and preventive health needs of the member.

An Initial Health Assessment (IHA) within one-hundred-twenty (120) days of a member's enrollment or within periodicity timelines established by the American Academy of Pediatrics for ages two and younger, whichever is less. The IHA must include a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services, health education, and the diagnosis and plan for treatment of any diseases.

The IHA for members under age 21 will be based on American Academy of Pediatrics (AAP) guidelines and will include the recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP). These preventive visits must include age specific assessments and services required by the Child Health and Disability Prevention program (CHDP).

The IHA for members over age 21 will meet the guidelines addressed in U.S. Preventive Services Task Force (USPSTF) and recommendations delineated in MHC's Preventive Health and Clinical Practice Guidelines.

It Matters TO MOLINA

MOLINA HEALTHCARE

BHT/ABA treatment

Who can provide BHT/ABA

BCBA or licensed clinician Provider

- Provides all services types - main function is to supervise the program and 1:1 direct staff, and complete assessments.
- A QAS provider is recognized as a BCBA or other nationally certified/licensed individual who has experience and competence designing, supervising or implementing ASD treatment (ex. Physician, Clinical Social worker, MFT).

BCaBA or MA level provider (aka QAS professional)

- Provides 1:1 direct service, social skills, and parent consultation.

Uncertified provider (aka QAS paraprofessional)

- Provides direct 1:1 therapy to child.
- Can also provide parent consultation.
    - *Molina exception - Master's level uncertified individuals may provide 75% of supervision, and bill as a QAS professional
    - *The professional and paraprofessional must be supervised by the provider

Request for prior authorization

- Authorization for services should be requested using the Molina PA request and include all supporting clinical documentation.
- MHC will process all non-urgent requests in no more than 5 business days of the initial request.
- Upon receipt of prior authorization request, MHC will give the provider a Molina unique authorization number. This authorization number must be used on all claims related to the service authorized.
- Providers who request prior authorization approval for services can request to review the criteria used to make the final decision. Providers may request to speak to the medical director/BCBA who made the determination to approve or deny the service request.

Supervision policy

- Supervision may be done by a QAS provider 100%, or divided 75% by a QAS professional and 25% by a QAS provider.
- Molina will recognize a QAS provider as either a BCBA or other licensed/certified individual with competence and experience in implementing ABA/BHT.
- Molina will recognize a QAS professional as either a BCaBA or an uncertified/unlicensed individual that meets the following qualifications:
  - The uncertified/unlicensed individual must:
    - Conform to the Health and Safety code for minimum standard of experience.
    - Possess a Bachelor of Arts or Science Degree and have either:
      - 12 semester units in applied behavior analysis and one year of experience in designing and/or implementing behavior modification intervention services or
      - Two years of experience in designing and/or implementing behavior modification intervention services.
  - Or be registered as either:
    - A psychological assistant of a psychologist by the Medical Board of California or Psychology Examining Board; or an Associate Licensed Social Worker pursuant to business and professions code, section 4996.818.

Service codes

	Service type	Modifier	Billing increment
H0031	Assessments used for the FBA. (ex. VB-MAPP, Vineland)	AH, HP, HO, HN, HM	1 Hour
H0032	Development of the treatment plan (FBA)	AH, HP, HO	1 Hour
H2019	Direct 1:1 treatment	AH, HP, HO, HN, HM	15 Minutes
H0046	Supervision of the 1:1 direct staff	AH, HP, HO, HN,	1 Hour
S5111	Parent and/or other provider consultation	AH, HP, HO, HN, HM	15 Minutes
H20014	Social Skills group with multiple patients	AH, HP, HO	15 minutes
90791	Psych Evaluation	AH	1 visit
96101, 96111, 96116, 96118, 96120	Psych Testing	AH, HP, HO, HN, HM depending on code selected	Generally, 1 hour, may vary with code selected

Modifiers

Definition (Provider)	Billing Modifier	QAS Level
Licensed Clinician (MD, Phd, LCSW)	AH	Provider (QASP)
Doctoral Level Certified Provider (BCBA-D) Board Certified Behavior Analyst-Doctoral	HP	Provider (QASP)
Masters Degree Level Certified Provider (BCBA) Board Certified Behavior Analyst	HO	Provider (QASP)
Bachelors Degree Level Certified Provider (BCaBA) or bachelor's level qualified professional Board Certified Assistant Behavior Analyst	HN	Professional (QASPRO)
Unlicensed or uncertified Provider	HM	Paraprofessional (QASPARA)

Term definitions are as defined in the California Health and Safety Code § 1374.73

Behavioral health

MOLINA® HEALTHCARE

Behavioral health provider resources

- Through our partnership with PsychHub, an online platform for digital mental health education, Molina network providers can access PsychHub's library of educational courses and material at no charge. The available online training courses, called Learning Hubs, are designed to unlock a library of companion videos and resources and offer certification or continuing education credits upon completion.

- Continuing education credits are available to select clinical licensures (i.e., social workers, nurses, etc.) for many of the courses. Throughout this toolkit, you will see applicable courses available through the PsychHub platform relevant to each topic. To create an account at no cost, please visit the Molina PsychHub landing page.

- Provider can also visit our website to view our Behavioral Health Toolkit. We designed this Behavioral Health Toolkit for providers to offer guidance regarding mental health and substance use conditions commonly seen in the primary care and community setting.

Behavioral health benefits overview

Covered by Molina all LOBs - No prior authorization (PA) needed with PAR provider

You may verify a service code on our PA look up tool

- Outpatient psychotherapy and psychiatry (90791, 90832, 90834, 90837, 90792, 99211, 99215) * no pre-set limits on sessions
- Outpatient family and group therapy (90847, 90853) *no pre-set limits on sessions
- Psychological and neuropsychological testing (96116, 966121, 96130, 96131, 96133, 96136, 93167, 96138, 96139, 96146) *first 4 hours, then PA needed

***Licensed, credentialed, PAR professionals and associates registered under their supervision may provide mental health services within their scope of practice and contract.**

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Behavioral health benefits overview

Prior auth needed for:

- Inpatient psychiatric & SUD rehabilitation: *authorized and covered by County Mental Health Plan for Medi-Cal
- Residential, partial hospitalization and intensive outpatient treatment for mental health and SUD *authorized and covered by County Mental Health Plan for Medi-Cal
- Eating disorder PHP, IOP, residential - service codes may overlap with some group therapy codes *Split risk between MCP and MHP for Medi-Cal
- Transcranial magnetic stimulation (TMS) (90867, 90868, 90869)
- Applied behavioral analysis (BHT/ABA) (H2019, S5111, H0031, H0032, H0046)

All services, treatment, and care by a non-par provider require prior authorization.

Behavioral health benefits overview

The "BH carve-out" applies to **Medi-Cal** members only.

- Substance Use Disorder (SUD) treatment outside of primary dare is authorized and covered by County Mental Health Plans (MHPs) and NOT Molina as a Managed Care Plan (MCP).
- **Medi-Cal members with SUDs who require treatment outside their primary care setting access services through the county carve-out.**

County	SUD Referral Number
San Bernardino	(888) 743-1478
Riverside	(800) 499-3008
San Diego	(888) 724-7240
Imperial	(800) 817-5292
Sacramento	(888) 881-4881
Los Angeles	(844) 804-7500

Behavioral health benefits overview

The "BH carve-out" applies to **Medi-Cal** members only.

- MHP provides specialty mental health services (SMHS), while MCPs provide non-specialty mental health services (NSMHS)
  (Outpatient psychotherapy, psychiatry, and TMS CPT codes overlap in both systems)

A DHCS screening tool is required when Members directly contact the MCP or MHP, and they are not already receiving mental health care. The screening tool yields a score telling us which system of care to access for a particular member. Scores 6 and above go to MHP, while scores 5 and below go the MCP network. Medi-Cal members may be evaluated in either system of care and providers are not required to use the screening tool.

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Behavioral health benefits overview

The "BH carve-out" applies to **Medi-Cal** members only.

If a PAR BH provider assesses a member (they are treating) needs a higher level of care due to serious impairment caused by a mental health condition, a **DHCS Transition of Care Tool must be completed** and sent to the MHP. This form is narrative with no scoring mechanism. At Molina we ask providers to send the form to us so we can track the transition and make sure the member receives the services they need.

A provider may also send clinical justification in the body of an email, and our Molina staff may complete the DHCS tool on their behalf. In the email, providers should also let us know if services are termed or if they are continuing to provide "bridge" tx. Our team will close the loop with the provider who has requested a transition. Members should be told by their provider that a transition is being requested and why.

Transition of care forms should be sent to: MHC_BH_Solutions@Molinahealthcare.com, with a subject line indicating *Step up to MHP from (provider name)*.

MHP= County Mental Health Plan; MCP= Managed care Plan (Molina

Coordination of care

Coordination of care

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 assists providers by identifying needs and issues that may not be verbalized by members, assisting to identify resources such as community programs, national support groups, and appropriate specialists and facilities. Molina also works collaboratively with providers to identify 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.

The Case Management Referral Form can be found on the Molina website. You can also refer to the Provider Manual for additional information.
Case management includes the following:

- For members 36 months to age 21 years old, providing or arranging for medically necessary diagnostic and treatment services necessary to correct and/or ameliorate conditions discovered in the screening process.
- Providing available medical documentation and reports, as requested, to the pediatric/RC case manager.
- Providing or arranging for medically necessary therapies and durable medical equipment.

Care coordination support

To refer a member for Complex Case Management, send a secure message to:

- Adults Medi-Cal: CMescalationCA@MolinaHealthCare.Com
- Pediatrics Medi-Cal and Marketplace: PedsCA@molinahealthcare.com
- Medicare: Medicare_CM_Team@Molinahealthcare.com
- Marketplace: CM_MPWest@molinahealthcare.com

You may attach this form to your email Link to Molina complex CM referral
Please visit our provider online directory to search for a provider.

To ask for help finding a mental health appointment, if your patient has no other outstanding care management needs, you may bypass the CM referral and call our BH Access Leads VM line. Providers may leave a detailed voicemail message at **(562) 549-4692**. The Behavioral Health team will contact the member the same day or the next day depending on the time they call. They will close the loop with you following member outreach.

***Members should call Molina Member Services. The voicemail line is not for distribution to members at this time.**

MOLINA® HEALTHCARE

Alcohol and drug screening, assessment, brief interventions and referral to treatment (SABIRT)

SABIRT

Requirement: PCPs must ensure unhealthy alcohol & drug screening (SABIRT) services are documented in the patient's medical chart/electronic medical record (EMR). Complete and accurate documentation is required to demonstrate compliance with Medi-Cal & Molina requirements.

How to screen all patient's unhealthy alcohol & drug use:

- Medi-Cal requires unhealthy alcohol and drug use for members 11 years of age & older, including pregnant women, using a validated screening tool, every year.
- When screening is positive, the provider must offer the member brief assessment, interventions and referral to treatment.
- Unhealthy alcohol and drug use screening must be conducted using validated screening tools. Validated screening tools include, but are not limited to: Cut down-annoyed-guilty-eye-opener adapted to include drugs (Cage-Aid); tobacco, alcohol, prescription medication and other substances (TAPS); National Institute on Drug Abuse (NIDA) quick screen; drug abuse screening test (DAST); alcohol use disorder identification test-consumption (AUDIT-C); partner, past, present (4Ps) for pregnant women; adolescents, car, relax, alone, forget, friends, trouble (CRAFFT) for non-pregnant adolescents; and Michigan alcoholism screening test geriatric (MAST-G) alcohol screening for geriatric population.
- Claim codes for screening & documenting a follow-up plan (for Medi-Cal):

SABIRT Billing Codes and Frequency Limits Table

Billing Code	Description	When to Use	Frequency Limit
G0442	Annual alcohol misuse screening, 15 minutes	Alcohol use screening	1 per year, per provider
H0049	Alcohol and/or drug screening	Drug use screening	1 per year, per provider
H0050+	Alcohol and/or drug services, brief intervention, per 15 minutes	Alcohol misuse counseling or counseling regarding the need for further evaluation/treatment	1 per day, per provider

SABIRT

How to assess patients when a screening is positive:

- When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include but are not limited to: NIDA-modified alcohol, smoking and substance involvement screening rest (NM-ASSIST), drug abuse screening test (DAST-20), and alcohol use disorders identification test (AUDIT).

Brief interventions and referral to treatment:

- For recipients with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable AUD or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:
  - Providing feedback to the patient regarding screening & assessment results
  - Discussing negative consequences that have occurred and the overall severity of the problem
  - Supporting the patient in making behavioral changes
  - Discussions and greeting on plans for follow-up with the patient, including referral to other treatment if indicated
- MCPs must make good faith efforts to confirm whether member receive referred treatments and document when, where, and any next steps following treatment. If a member does not receive referred treatments, the MASP must follow up with the member to understand barriers and make adjustments to the referrals is warranted. MCPs should also attempt to connect with the provider to whole the member was referred to facilitate a warm hand off to the necessary treatment.

Documentation:

- Member medical records must include the following:
  - The service provided, name of the screening instrument and score on the screening instrument, name of the assessment instrument and score on the assessment; and if and where a referral to an AUD or SUD program was made.

SABIRT

Documentation (continued):

- PCPs must maintain documentation of SABIRT services provided to members. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventative services.
- Why unhealthy alcohol and drug use screening is critical:
- Unhealthy alcohol & drug use plays a contributing role in a wide range of medical and behavioral health conditions. Counseling interventions is the primary care setting can address risky drinking behaviors in adults by reducing weekly alcohol consumption and increasing long-term adherence to recommended drinking limits. Brief behavioral counseling interventions decrease the proposition of the persons who engage in episodes of heavy drinking. Additionally, brief counseling interventions increase the likelihood pregnant women will abstain from alcohol throughout their pregnancy. Effective treatment options for AUDs and/or substance use disorders depend on the severity of the disorder and include some combination of the following: alcohol and/or drug counseling sessions, participation in mutual help groups. Structured, evidence-based psychosocial interventions, Federal Drug Administration-approved medication, residential treatment (when medically necessary), or some combination of these services.

Resources:

- County alcohol and drug treatment referral lines and websites
  - Los Angeles: Substance Abuse Prevention & Control (SAPC) at: (888) 742-7900
  - LA County Department of Public Health - Substance Abuse Prevention and Control
  - San Bernardino: Substance Abuse Screening Assessment & Referral Center (SARC) at: (909) 421-4601
  - DBH Internet Website (sbcounty.gov)
  - Riverside: Substance Use CARES Line at: (800) 499-3008
  - Substance Abuse Prevention & Treatment Locations (rcdmh.org)
  - Imperial: Imperial County Access Unit at: (442) 265-1597 or (442) 265-1596
  - Sacramento: Sacramento County Access Team at: (916) 875-1055
  - San Diego: San Diego County Access & Crisis Line at: (888) 724-7240
  - Alcohol and Drug Services (ADS) (sandiegocounty.gov)

Emergency department protocol

MOLINA® HEALTHCARE

Emergency services definition

- **Emergency services** are services needed to evaluate or stabilize an **emergency medical condition.**
- An **emergency medical condition** is one where someone exhibits symptoms of severity – including severe pain – such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
  - Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
  - Serious impairment to bodily functions, or
  - Serious dysfunction of any bodily organ or part

Prior authorizations	Notification requirements	Aftercare
• Emergency services under the above definition do not require MHC prior authorization. In accordance with California Department of Health Care Services' policies and current law, members presenting to an emergency room facility may be triaged by the emergency room staff, and MHC will pay the medical screening exam fee.	• MHC requires timely notification to the EDSU for any post stabilization services, i.e., inpatient admission. EDSU authorization requests should be communicated telephonically while the member is in the emergency room. EDSU's dedicated phone and fax number is used exclusively for members currently in the ER, to help expedite requests and assist with discharge planning.	• Aftercare instructions should be documented in the emergency facility medical record and communicated to the patient, parent, or guardian. Discharge from the emergency facility is performed on the order of a provider. For transfer requests and discharge planning authorizations, after hours, weekends and holidays, please contact the EDSU.

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Emergency department support unit (EDSU)

The EDSU will collaborate with providers to ensure MHC members receive the care they need, when they need it.

EDSU 24/7 support:

- Assisting providers in determining appropriate level of placement using established clinical guidelines
- Issuing authorizations for post-stabilization care, transportation, or home health
- Involving a hospitalist or on-call medical director for any peer-to-peer reviews needed
- Working with pharmacy to coordinate medications or infusions as needed
- Obtaining SNF placement if clinically indicated
- Coordinating placement into case management with MHC when appropriate
- Beginning the process of discharge planning and next day follow-up with a primary care provider if indicated

To request authorization of post-stabilization services, call the EDSU at:
(844) 966-5462

To submit clinical records for authorization of post-stabilization care, fax the EDSU at:
(877) 665-4625

MOLINA® HEALTHCARE

Eligibility, enrollment and disenrollment

MOLINA® HEALTHCARE

New members

- Molina Healthcare of California (MHC) receives EDI 834 benefit enrollment and maintenance transactions from DHCS and weekly Health Care Options (HCO) data files.
- The data received from HCO is matched to the processed EDI 834 and stored in MHC's core operating system.
  - MHC Availity Essentials Portal: provider.MolinaHealthcare.com
  - IPA/medical group eligibility list/Molina Healthcare Interactive Voice Response at (888) 665-4621
  - MHC's member services department at (888) 665- 4621
- If the member does not appear on the current eligibility roster, the provider/practitioner should contact MHC's provider services department at (855) 322-4075
- At no time should a member be denied services because their name does not appear on the eligibility roster. Please remember that a member may access emergency services without prior authorization.

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Eligibility and eFiles

- Providers are encouraged to register and use the Molina's provider web portal as a primary method to check members' eligibility information: provider.molinahealthcare.com.

- The MHC interactive voice response (IVR) system notifies both providers/practitioners and members of member eligibility status and PCP assignment. The system has a dedicated phone line at (800) 357-0172 and is available 24 hours a day, 365 days a year.

- MHC distributes eligibility reports monthly to provide information on member enrollment in an IPA/medical group. The reports are generated the first week of each month and mid-month MHC Medi-Cal members who have changed providers/practitioners by the 15th of the month will be in effect for the currently calendar month.

- Members who have changed providers/practitioners on or after the 16th of the month will be in effect the first day the month following the next month. These files are secured and password protected and can only be accessed by the IPA/medical group designee that are identified as the recipient. For additional details of the IPA/medical group eligibility list files, please contact your Provider Services representative.

Member disenrollment

- Providers are encouraged to register and use the Molina's provider web portal as a primary method to check members' eligibility information: provider.molinahealthcare.com.
- Any member of MHC may at any time, without cause, request to be disenrolled from the plan. The member must contact HCO at (800) 430-4263. An HCO representative will mail a disenrollment form to the member's residence.
- A member with a mandatory aid code must simultaneously re-enroll into another managed care health plan.
- If the member fails to select a health plan, HCO will automatically assign them to one.
- Members who have a voluntary aid code may elect to remain in the Medi-Cal fee-for-service program or select a new health plan.
- Until the member's disenrollment request is approved and processed by DHCS, MHC will be responsible for the member's health care.
- **Disenrollment of a member is mandatory under the following conditions:**
  - Member requests to be disenrolled
  - Member loses Medi-Cal eligibility
  - Member moves out of the plan's approved service area
  - Member's Medi-Cal aid code changes to an aid code not covered
  - Member's enrollment violates the state's marketing and enrollment regulations
  - Member requests disenrollment as a result of a plan merger or reorganization
  - Member is eligible for those carve-out services that require disenrollment (see additional services or carve-out services).

Medical record documentation

MOLINA® HEALTHCARE

Medical records

- Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to members is consistently documented and that necessary information is readily available in the medical record.
- All entries will be indelibly added to the member's record. PCPs should maintain the following components, that include but are not limited to:
  - Medical records confidentiality and release of medical records are maintained including behavioral health care records.
  - Medical record content and documentations standards are followed, including preventative health care.
  - Storage maintenance and disposal processes.
  - Process for archiving medical records and implementing improvement activities.
- Retrieval
  - The medical record is available to provider at each encounter.
  - The medical record is available to Molina for purposes of quality improvement.
  - The medical record is available to the applicable state and/or federal agency and the external quality review organization upon request.
  - The medical record is available to the member upon their request.
  - A storage system for inactive member medical records which allows retrieval within 24 hours, is consistent with state and federal requirements, and the record is maintained for not less than 10 years from the last date of treatment of for a minor, one year past their 20th birthday but, never less than 10 years.
  - An established and functional data recovery procedure in the event of data loss.

Medical record-keeping practices and organization

- Below is a list of the minimum items that are necessary in the maintenance of the member's medical records:
  - Each patient had a separate record.
  - Medical records are stored away from patient areas and preferably locked.
  - Medical records are available at each visit and archived records are available within 24 hours.
  - If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates.
  - If electronic, all those with access have individual passwords.
  - Record keeping is monitored for quality and HIPAA compliance.
  - Storage maintenance for the determined timeline and disposal per record management processes.
  - Process for archiving medical records and implementing improvement activities.
  - Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.
- Organization:
  - The medical record is legible to someone other than the writer.
  - Each patient has an individual record.
  - Chart pages are bound, clopped or attached to the file.
  - Chart sections are early recognized for retrieval of information.
  - A release document for each member authorizing Molina to release medical information for facilitation of medical care.

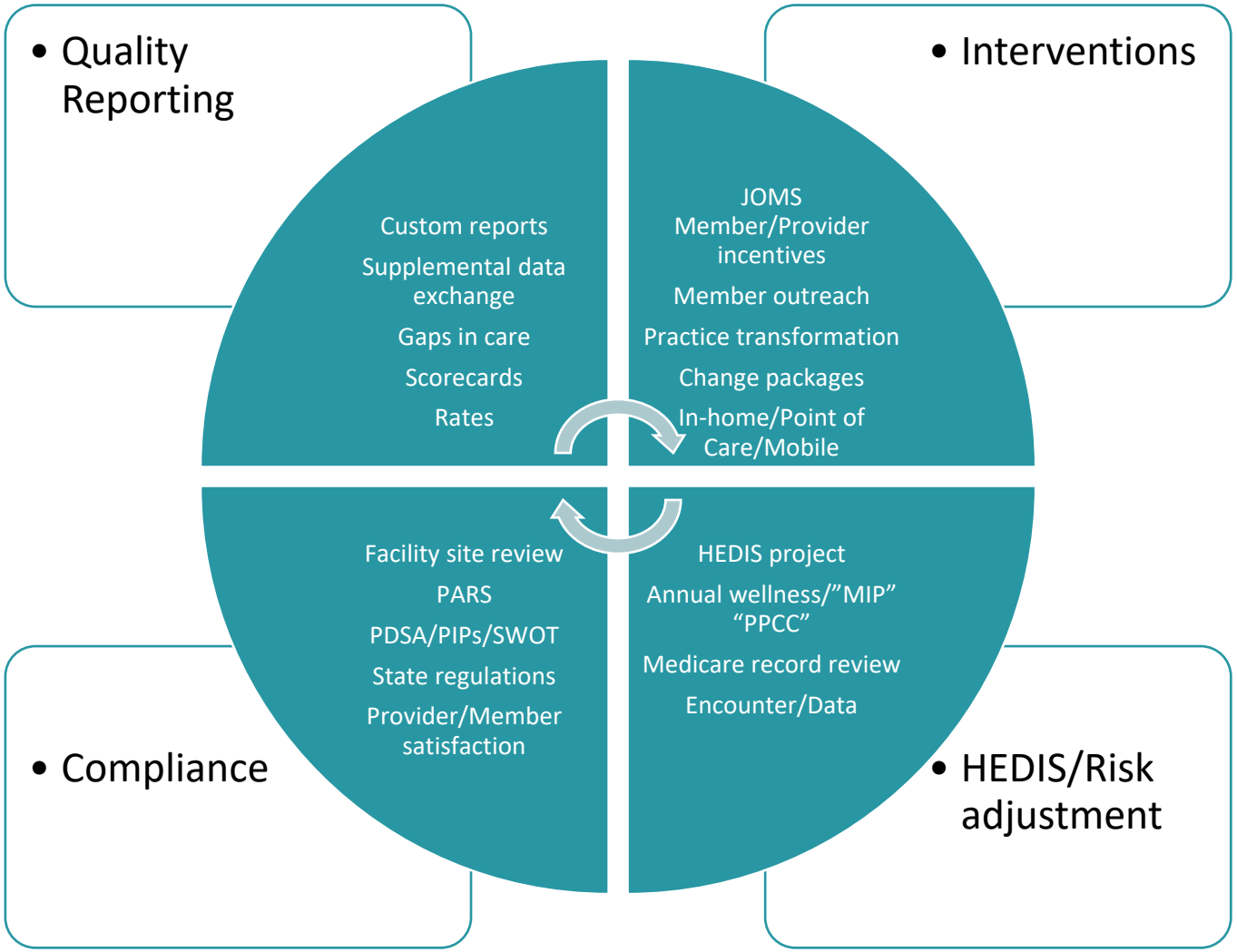
Medical record confidentiality

- Molina providers shall develop and implement confidentiality procedures to guard member protected health information, in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include, and is not limited to, the following:
  - Ensure that medical information is released only in accordance with applicable federal or state Law in pursuant to court orders or subpoenas.
  - Maintain records and information in an accurate and timely manner.
  - Ensure timely access by members to the records and information that pertain to them.
  - Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health an enrollment information.
  - Medical records are protected from unauthorized access.
  - Access to computerized confidential information is restricted.
  - Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
  - Education and training for all staff on handling and maintain protected health care information.
- Additional information on medical records is available from your local Molina quality department toll free at (800) 526-8196, ext. 126137. See the compliance section of the provider manual for additional information regarding HIPAA.

Quality improvement

MOLINA® HEALTHCARE

Quality improvement department

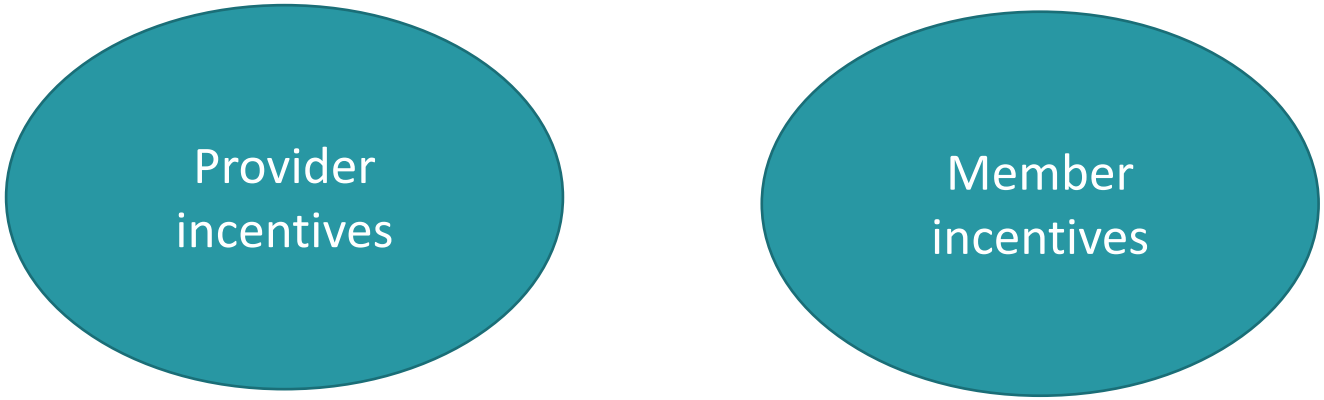


MOLINA® HEALTHCARE

Quality improvement department

Molina's quality team monitors NCQA HEDIS measure/rates, provider incentives, member incentives, state initiatives, as well as any reporting.

We do this to collaborate with and improve our partners' HEDIS scores and patient care. We encourage and share all tools available to help patients get the best care they possibly can. If you have any questions, please reach out to your assigned practice facilitator below.



Provider and member incentives vary from county to county. Please contact your practice transformation specialist for specific information.

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Practice transformation specialists

Please reach out your county specific specialist for interventions, provider/member incentives, any provider report requests

Region	PARS, P4P, HEDIS, and Gaps in Care Questions
Imperial	• Fernanda Garate Fernanda.Garate@MolinaHealthcare.com
San Diego	• Cindy Santa Cruz Cindy.SantaCruz@MolinaHealthcare.com
Inland Empire	• Avery Slaughter Avery.Slaughter@MolinaHealthcare.com • Michelle Mora Michelle.Mora2@MolinaHealtcare.com • Rocio Chavez Rocio.Chavez1@molinaHealthcare.com • Samwendy Asiamah samwendy.asiamah@molinahealthcare.com
Los Angeles	• Rocio Chavez Rocio.Chavez1@molinaHealthcare.com • Michelle Mora Michelle.Mora2@MolinaHealthcare.com
Sacramento	• Elizabeth Hill Elizabeth.Hill@MolinaHealthcare.com

MOLINA® HEALTHCARE

Facility site review

MOLINA HEALTHCARE

Facility site review

WHAT is a site review?

Facility site review (FSR)

Medical record review (MRR)

Physical accessibility review survey (PARS).

WHO requires a site review?

All PCP sites participating in the Medi-Cal Managed Care Program

WHY are site reviews conducted?

FSRs are conducted to ensure that all contracted PCP sites have sufficient capacity to provide appropriate primary healthcare services and can maintain patient safety standards and practices.

California Code of Regulations (22 CCR § 56230)

California Department of Health Care Services (DHCS) All Plan Letter 22-017

MHC Policies & Procedures

WHEN is a site review needed?

Initial site review is conducted during the initial credentialing process

Periodic site review is conducted at least every 3 years thereafter

MOLINA HEALTHCARE

Facility site review

Important facility and medical record review changes (7/1/22)

- Department of Health Care Services (DHCS) has updated the facility site review (FSR) and medical record review (MRR) criteria that Molina nurse reviewers use as the tools to conduct initial and periodic audits.
- The updates are aligned with local, state, and federal guidelines, as well as recommendations from national experts in prevention and evidence-based medicine, to ensure the provision of preventive services are in accordance with:
  - American Academy of Pediatrics, Bright Futures;
  - US Preventive Services Task Force, Grade A and B recommendations;
  - American College of Obstetricians and Gynecologist/Comprehensive
  - Perinatal Services Program; and
  - Advisory Committee on Immunization Practices

The Medi-Cal Managed Care Plans in California have collaborated to create FSR and MRR training videos in order to assist you in preparing for these changes. You can view the training videos here!

Fraud prevention

MOLINA® HEALTHCARE

Ethical standards

Molina Healthcare of California ("Molina") seeks to uphold the highest ethical standards for the provision of health care benefits and services to its members and supports the efforts of federal and state authorities in their enforcement of prohibitions of fraudulent practices by providers or other entities dealing with the provision of health care services.

- **“Abuse”** means practices that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the Medicaid/Medicare programs or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid/Medicare programs. (**42 CFR 455.2** and as further defined in Welf. & Inst. Code Section 14043.1 (a).)

- **"Fraud"** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (**42 CFR 455.2** W. & I. Code Section14043.1(i).)

Examples of fraud and abuse

By a Member	By a Provider
• Using someone else's insurance card	• False coding, records, or altered claims
• Forging a prescription	• Billing for services not rendered or goods not provided
• Knowingly enrolling someone not eligible for coverage under their policy or group coverage	• Billing separately for services that should be a single service
• Providing misleading information on or omitting information from an application for health care coverage, or intentionally giving incorrect information to receive benefits	• Billing for services not medically necessary
• Altering the billed amount for services Altering the service date	• Overutilization: Medically unnecessary diagnostics, unnecessary durable medical equipment, unauthorized services, inappropriate procedure for diagnosis

Additional provider crimes:

- Knowingly and willfully solicits or receives payment of kickbacks or bribes in exchange for the referral of Medicare or Medicaid patients
- A physician knowingly and willfully referring Medicare or Medicaid patients to health care facilities in which or with which the physician has a financial relationship (The Stark Law)
- Balance billing Medi-Cal Members - asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees

Reporting fraud and abuse

- You may report suspected cases of fraud and abuse to Molina's Compliance Officer.
- You have the right to have your concerns reported anonymously to Molina, the California Department of Health Services, and/or United States Office of Inspector General.
- When reporting an issue, please provide as much information as possible. The more information provided the better the chance the situation will be successfully reviewed and resolved.
- Include the following information when reporting suspected fraud or abuse:
    - Nature of complaint
    - The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information
    - Molina Healthcare AlertLine: **(866) 606-3889**

Fraud, waste and abuse

You may anonymously report fraud and abuse to Molina through one of the following:

- **By phone**
  Call the Toll-Free number of the Molina Healthcare of California, Molina Healthcare AlertLine: **(866) 606-3889**
- **Website**
  www.MolinaHealthcare.alertline.com
- **Regular mail**
  - Write (**marked confidential**) to: **Compliance Officer**
    Molina Healthcare of California
    200 Oceangate, Suite 100
    Long Beach, CA 90802
- **California Department of Health Care Services, or United States Office of Inspector General by:**
  - Calling the toll-free number of the Department of Health Care Services Anti-Fraud Line: **(800) 822-6222** or sending an e-mail to: stopmedicalfraud@dhcs.ca.gov
  - Call the toll-free number of the Office of Inspector General: **(800) 447-8477**

MOLINA® HEALTHCARE

Molina Healthcare of California

New Provider Orientation/Training

Checklist & Acknowledgement Form

This is to confirm that the below Provider has received a Molina Healthcare of California (MHC) New Provider Orientation (NPO) and/or Provider In-Service. To ensure compliance, the Provider understands the discussed policies/procedures and Provider/Practitioner Manual, which contains additional contact information and describes in detail MHC's key policies and procedures by applicable line(s) of business.

☐ New Provider Orientation ☐ Provider In-Service

Provider Type (check applicable box):		**Line of Business (check applicable box):**	
☐ IPA PCP	☐ Direct PCP	☐ Medi-Cal	☐ Cal MediConnect (MMP)
☐ Specialists	☐ Other:_____	☐ Market Place	☐ Medicare Options Plus (MMOP)

NPO Topics

Molina Healthcare Background Information
- The Molina Healthcare Story & State Fact Sheet

Contact Information
- Provider Quick Reference Guide & Transportation
- Provider Demographic Process (adds, modifications, terminations) – **If Applicable**
- Emergency Care Reference Sheet

Prior Authorization
- Prior Authorization Guide (If Applicable)
- Autism Spectrum Disorder/Behavioral Health COC Form

Pharmacy Prior Authorization
- Medication Prior Auth. Request Form
- Condensed Formulary

California Children's Services (CCS)
- CCS Job Aid & SAR Forms

Case Management
- Complex Case Management Criteria
- MHC Case Management Referral Form

Preventive Care Services
- Initial Health Assessment (Refer to Provider Manual)
- Staying Healthy Assessment (SHA)
- DHCS SHA Training Attestation & Sign-In Forms
- Screening, Brief Intervention Referral to Treatment (SBIRT)
- SBIRT Training Attestation & Sign-In Forms
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Pay-For-Performance Program (If Applicable)
- Medi-Cal Pay for Performance Program, including Child Health & Disability Prevention (CHDP)
- Medicare Annual Comprehensive Exam (ACE)

Cultural & Linguistic (C&L) / Health Education
- Access to Care Standards/Patient Satisfaction
- Bridge2Access & Sensitive Training (Handouts)
- C & L / Health Education Resources
- Pregnancy Notification Form
- Health Education Referral/Material Request Form
- Comprehensive Tobacco Cessation Services

Claims Information (If Applicable)
- Claims Job Aid & Processing Standards
- Provider Dispute Resolution
- Electronic Fund Transfer (EFT)

Web Portal
- How to Register
- Utilizing Web Portal Submission of PM160s (If Applicable)

Member Rights & Responsibilities
- Sterilization Consent & Member Grievance Forms

Fraud, Waste, & Abuse (FWA)

Additional Provider Resources/Tools
- Provider Manual (MHC and/or Health Net)
- Pharmacy Drug Formulary
- HEDIS Provider/Risk Adjustment Pocket Guide
- Molina Provider Education Series (ADA, CBAS, etc.)
- Medicare/MMP/Marketplace Benefits At-A-Glance
- Molina Dual Options Provider Orientation

*MHC Provider Manuals are available: www.MolinaHealthcare.com. To receive hard copy provider manuals, please request from your Provider Services Representative.

Other Topics Discussed (Indicate Below): _____

_____

Date: _____

Provider Name (Print): _____

Site Address: _____

_____

Authorized Staff Name (If Applicable): _____

Signature: _____

Effective Date: _____

MHC PS Rep Name: _____

MemorialCare Select Health Plan New Provider Orientation

MCSHP.org

MemorialCare
Select Health Plan

MemorialCare
Select Health Plan

Congratulations!

You have successfully completed MemorialCare Select Health Plan's contracting process and are now part of the Memorial Care Select Health Plan provider network.

In this packet you will find useful information about:

- Contacts
- Provider website
- Provider Portal registration
- Claims submission
- Contracted providers

Please orient your staff to requirements detailed in this packet, the Provider Manual, and other resources. Additional information can be found on the MemorialCare Select Health Plan's website at www.mcshp.org. You may contact us at (855) 367-7747 for assistance with access, training or general inquiries.

Welcome and thank you for your participation in providing care to our members.

Sincerely,

Maribel Ferrer
Chief Executive Officer
MemorialCare Select Health Plan

MemorialCare
Select Health Plan

Contact Information

Administrative Department	
Maribel Ferrer	**657-241-3900**
CEO	MFerrer3@memorialcare.org
Gina Ramirez	**657-241-3900**
Executive Assistant	gramirez@memorialcare.org
Claims Department	
Scott Davidson	**657-241-3900**
Manager, Claims	SDavidson@memorialcare.org
Finance & Enrollment Department	
Mark Gunter	**657-241-3900**
Director, Finance	MGunter@memorialcare.org
Hieu Han	**657-241-3900**
Manager, Enrollment	HHan@memorialcare.org
Medical Management Department	
Scott S. Ferer, MD	**657-241-3900**
Chief Medical Officer	SFerer@memorialcare.org
Deborah Schutz, RN, JD	**657-241-3900**
Director, Medical Management	DSchutz@memorialcare.org
Quality & Credentialing Department	
Amy Adkins-Dwivedi	**657-241-3900**
Quality Manager	AAdkinsdwivedi@memorialcare.org
Provider Contracting Department	
Mark Kroeger	**657-241-3900**
Executive Director Managed Care	MKroeger@memorialcare.org
Angela Donatoni	**657-241-3900**
Sr. Contract Manager	ADonatoni@memorialcare.org
Member & Provider Services Department	
Nicole Morales	**657-241-3900**
Manager, Member & Provider Services	NMorales@memorialcare.org
MemorialCare Select Health Plan Web Address	
www.memorialcareselecthealthplan.org	
www.mcshp.org	

General Information	
MemorialCare Select Health Plan	
17360 Brookhurst Street	
Fountain Valley, CA 92708	
S01:	(844) 805-8700
Main:	(657) 241-3900
Toll free:	(855) 367-7747
TTY:	711
Reaching a Representative	
Listen for automated voice	
Choose department:	
1-Claims	
2-UM (Auths, Hospitals, CM)	
Listen for automated voice	
2-CM	
3-Eligibility	
4-Contracting/Provider Services/Cred	
Claims Address	
MemorialCare Select Health Plan	
P.O. Box 20900	
Fountain Valley, CA 92728	
Fax Numbers	
Admin	657-241-3960
Receptionist	657-241-3960
Claims	562-933-1893
Credentialing	562-912-1248
Finance/Enrollment	562-595-1345
Info Services	657-241-3960
Managed Care	562-424-1614
Quality	562-933-1892
UM	562-933-1891
UM Case Mgmt.	562-933-1890

MemorialCare
Select Health Plan

HOW TO NAVIGATE THE WEBSITE
Step 1: Go to www.mcshp.org or www.memorialcareselecthealthplan.org
Step 2: Select "For Providers"
FOR THE PROVIDER PORTAL
Step 3: If registered, Click on "Provider Portal MC Link" to be directed to the Provider Portal log-in page.
Step 4: If NOT registered, Follow the information provided in the "MCLink How to Guide" on how to register for the MC Link Provider Portal.
FOR PROVIDER MANUALS
Step 5: Find the "Provider Manuals" under the Provider Services Contact Information section.
FOR OTHER RESOURCES
Step 6: Find more information under the "Other Resources" section for Language Assistance, Health Education, Utilization Management, and Provider Updates.
FOR CLAIMS
Step 7: Click on the "Claims Information" button found under the Other Resources section.

Provider Manual
The Provider Manual is a reference tool for providers and office staff outlining basic processes that support the provision of contracted health care services to MemorialCare Select Members. Providers are responsible for ensuring appropriate staff review and understand the Provider Manual. The Provider Manual is reviewed and updated at least annually and is available online.

Provider Portal
The Provider Portal connects Providers to real-time eligibility, benefits, claims, and authorizations information and other helpful resources. For initial access to the Provider Portal please complete and submit Provider Portal Access Request form.

Member Eligibility
It is important that Providers verify eligibility. The Primary Health Plan ID card does not guarantee eligibility. Eligibility may change monthly; a member eligible on the last day of the month may not be eligible on the first of the following month. Claims submitted for non-eligible members will not be paid.

Member eligibility can be verified through the Provider Portal or directly by the Primary Health Plan.

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Contact	Phone Number/Fax	Website
AEVS (Medi-Cal)	(800) 456-2387	
Medi-Cal		https://www.medi-cal.ca.gov/Eligibility/Login.asp
Primary Health Plan		
L.A. Care Health Plan[1]	(844) 901-7272	http://lacare.org/providers/provider-sign-in/check-coverage
Anthem Blue Cross[2]	• Medi-Cal (LA Care): (888) 285-7801 • Regional Health Plans (Southern CA) (818) 291-6914	https://mediproviders.anthem.com/ca/Pages/eligibility-capitation-reports.aspx
Health Net[3]	• Health Net Provider Services Center (Except Medi-Cal and Medicare) (800) 641-7761 • Provider Services Medi-Cal (800) 675-6110 (800) 281-2999 (fax) • Provider Services Medicare Advantage Plans (800) 929-9224 (800) 646-5614	https://www.healthnet.com/portal/provider/content/iwc/provider/unprotected/dashboard/content/jan_service_notice.action#
Blue Shield[4]	• (800) 393-6130	https://www.blueshieldca.com/provider/account-tools/login/home.sp
Alignment	• (866) 517-2247	https://www.alignmenthealthplan.com/providers

MemorialCare
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Claims and Encounters

Paper Claims, Appeals & Disputes	Electronic Encounters
Send all paper claims, appeals and disputesto the following: MemorialCare Select Health Plan Claims Department P.O. Box 20900 Fountain Valley, CA 92708	Office Ally Payor ID: 46187 (Claims) Payor ID: E4618 (Encounters) www.officeally.com/resourcecenter.asp Change Health Care Payor ID: 46187 (Claims) Payor ID: E4618 (Encounters) https://cda.changehealthcare.com/Portal/

Federal False Claims Act (FCA)

MemorialCare Select Health Plan complies with all applicable federal and state laws including the Federal False Claims Act (FCA). The federal False Claims Act (31 USC § 3729-33 is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim to any program funded directly, in whole or in part, by the federal government.

Examples of Federal False Claims Act Violations:

- Submitting a false claim for payment,
- Making or using a false record or statement to obtain payment for a false claim,
- Conspiring to make a false claim or get one paid, or
- Making or using a false record to avoid payments owed to the U.S. Government.

Penalties for violating the federal False Claims Act are significant. Financial penalties for submitting a false claim can total as much as three times the amount of the claims, plus fines of $5,500 - $11,000 per claim.

The False Claims Act also protects individuals who report alleged fraud in good faith from retaliation. MemorialCare Select Health Plan will investigate allegations of fraud, waste and abuse – and reports of non-compliance on any level.

You can report your concern anonymously by calling or emailing the **Compliance & Ethics Hotline**.

Compliance & Ethics Hotline

Available 24/7, 365 days of the year

Dial toll-free: 888-933-9044 *OR* **Online:** memorialcare.ethicspoint.com

MemorialCare
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Member Services

The Member's Primary Health Plan contact information can be found on the Member ID card. The Primary Health Plan provides members services, including:

- General Member Services
- Language Assistance Program (interpretation and translation services)
    - Access via the Primary Health Plan's member services phone number
- Member Appeals and Grievances

Providers

Primary Hospital Network	Laboratory
Primary Hospital Network • MemorialCare Long Beach Medical Center (562) 933-1000 • Miller Children's and Women's Hospital Long Beach (562) 933-5437	*Laboratory* • Quest Diagnostics (866) 697-8378

Affirmative Statement about Incentives

MemorialCare Select Utilization Management decision making is based only on appropriateness of care, service, and existence of coverage; the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service care; financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

MemorialCare
Select Health Plan

Member Rights

As a MemorialCare Select Health Plan member, you have the ***right to:***

- **Respectful and courteous treatment**. You have the right to be treated with respect, dignity and courtesy from your health plan's providers and staff. You have the right to be free from retaliation or force of any kind when making decisions about your care.
- **Privacy and confidentiality**. You have the right to have a private relationship with your provider and to have your medical record kept confidential. You also have the right to receive a copy of, amend, and request corrections to your medical record. If you are a minor, you have the right to certain services that do not need your parents' okay.
- **Choice and involvement in your care**. You have the right to receive information about your health plan, its services, its doctors and other providers. You have the right to choose your primary care provider (PCP) from the doctors and clinics listed in your health plan's provider directory. You also have the right to get appointments within a reasonable amount of time. You have the right to talk with your doctor about any care your doctor provides or recommends, discuss all treatment options, and participate in making decisions about your care. You have the right to a second opinion. You have the right to talk candidly to your doctor about appropriate or medically necessary treatment options for your condition, regardless of the cost or what your benefits are. You have the right to information about treatment regardless of the cost or what your benefits are. You have the right to decline treatment. You have a right to decide in advance how you want to be cared for in case you get a life-threatening illness or injury.
- **Receive timely customer service**. You have the right to wait no more than 10 minutes to speak to a customer service representative during MemorialCare Select Health Plan's normal business hours.
- **Voice your concerns**. You have the right to complain about MemorialCare Select Health Plan, the health plans and providers we work with, or the care you get without fear of losing your benefits. MemorialCare Select Health Plan will help you with the process. If you don't agree with a decision, you have the right to appeal, which is to ask for a review of the decision. You have the right to disenroll from your health plan whenever you want. *As a Medi-Cal member, you have the right to request a State Fair Hearing*.
- **Service outside of your health plan's provider network**. You have the right to receive emergency or urgent services as well as family planning and sexually transmitted disease services outside of your health plan's network. You have the right to receive emergency treatment whenever and wherever you need it.
- **Service and information in your language**. You have the right to request an interpreter at no charge instead of using a family member or friend to interpret for you. You should not use children to interpret for you. You have the right to get the Member Handbook and other information in another language or format (such as audio, large print or Braille).
- **Know your rights**. You have the right to receive information about your rights and responsibilities. You have the right to make recommendations about these rights and responsibilities.
- **Talk to a Registered Nurse any time, day or night, about health questions or worries about symptoms**. You can contact your Primary Health Plan for 24-hour Nurse Advice Service by calling the phone number on your Primary Health Plan Member's ID Card or on your Primary Health Plan's website.